School children and self-harm: Staff perspectives and concerns

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IV

Abstract

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Title: School children and self-harm: Staff perspectives and concerns

Purpose: The aim of this study was to describe the experiences, understandings and concerns elementary school staff have of self-harm among Norwegian elementary school children (6-13 years). This is an independent research project which received no funding.

Method: Data were collected through face-to-face interviews using a semi-structured interview guide and through an online survey designed by the authors. Data analysis was informed by both the thematic approach and Interpretative Phenomenological Analysis (IPA).

Participants: Elementary school staff in Norway. 63 staff members responded to the survey and 15 additional staff members were interviewed. All interview participants had some prior experience or knowledge of children who self-harmed.

Results: Three themes resulted from the analysis: 1. Participants' understandings of self-harm, 2. social learning of self-harm, and 3. a call for more knowledge. Staff tend to dichotomize between what is serious and what is not and express uncertainty about what behaviors should be labeled self-harm. Self-harm is frequently understood as an emotion regulation strategy or as a "cry for help" where the self-harm is seen as a clear signal of a child in distress. Staff expressed concern of social learning effects if self-harm is introduced as a topic for children. Staff appraisals of their own competence to manage children who self-harm were low, and many expressed a desire to receive outside help and to gain more knowledge of self-harm. Findings were supported by survey data.

Conclusion: School staff are in a privileged position to uncover self-harm among children and provide help and early intervention. The authors suggest that staff must be provided with more knowledge on self-harm to increase visibility and understanding, and that all children who display warning signs must be spoken to individually. Increased knowledge will help staff feel more secure in dealing with children who self-harm and may increase their efficacy and promote positive attitudes. A counselor should be available at all elementary schools to provide an alternative to the external helping system which is generally less available.

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Ann Kristin Svendsen

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1 Introduction

The majority of self-harm research focuses on adolescents or adult samples and there is a pronounced scarcity of studies done on younger children. However, recent reports suggest that young children do engage in self-harming behaviors[1]. The lack of studies calls for more research regarding what risk factors to be aware of, what kind of self-harm behaviors younger children engage in and how best to help these children. Such research can help raise awareness of the issue and thus increase the probability of early discovery and intervention. The study of self-harm in children could provide insights about how and when to best prevent children and adolescents from engaging in maladaptive coping styles. Therefore, we find the study of children and self-harm important. We aimed to make a contribution through interviewing Norwegian elementary school staff about their experiences and understandings of self-harm among elementary school children. School staff interact with children for many hours each day, and they play an integral role in their lives. We consider school staff to be in an advantageous position where they can observe children and gain information about what goes on in their lives and the systems around them, also when it comes to self-harm. This study is the first of its kind in Norway. We begin by giving a review of the literature on self-harm focusing on research relating to children in particular, as well as elementary schools' significance regarding children's mental health, with specific emphasis on self-harm.

1.1 General overview of self-harm

1.1.1 What is self-harm?

Inflicting intentional harm to one's own body is behavior seemingly at odds with the innate drive for survival and good health which can be found in all animals. Even so, self-harm has been mentioned throughout the recorded history of humans. In the New Testament, cutting oneself was associated with being possessed by demons (New International Version, Mark 5:2-5). In 1987 the American psychiatrist Dr. Armando Favazza published *Bodies Under Siege: Self-mutilation in Culture and Psychiatry*, which was the first psychiatric book on self-harm. He divided self-harm into two broad categories; culturally sanctioned and deviant, and helped teach clinicians that self-injurious behavior differs from suicidal behavior (Favazza,

[1] See for example Barrocas, Hankin, Young and Abela, (2012), Hawton and Harriss (2008) and Simm, Roen and Daiches (2008).

1987). How to define self-harm has been the subject of discussion, as there are choices to be made about where lines would best be drawn (Turp, 2002). What a society judges to be deviant behavior will be the subject of debate and continuing negotiation. As for children, it may be the case that they present with different forms of self-harm behavior compared to what is usually seen in adolescents and adults.

There is no agreed-upon definition of what behaviors count as self-harm, and various studies often employ different sampling methods, measuring instruments and time frames (Muehlenkamp Claes, Havertape & Plener, 2012), making cross-study comparison problematic. The term used to describe self-harm varies depending on what definition is employed. *Deliberate self-harm* (DSH), *self-injury*, *non-suicidal self-injury* (NSSI), *self-injurious behavior* (SIB), *self-mutilation* and *parasuicide* are concepts that have been used interchangeably in the literature. A European multi-center collaboration coined The Child and Adolescent Self-harm in Europe (CASE) Study (2005)[2] used the following definition of self-harm:

> An act with a non-fatal outcome in which an individual deliberately did one or more of the following: a. Initiated behavior (for example, self-cutting, jumping from a height), which they intended to cause self-harm. b. Ingested a substance in excess of the prescribed or generally recognized therapeutic dose. c. Ingested a recreational or illicit drug that was an act that the person regarded as self-harm. d. Ingested a non-ingestible substance or object. (Madge et al., 2008, p. 669)

DSH is frequently used as a broader category of self-injurious behaviors both with and without suicidal intent that have non-fatal outcomes and is commonly used in European and Australian studies. In the United States and Canada, many studies have employed NSSI, which excludes behaviors with any level of suicidal intention (Muehlenkamp et al., 2012). Certain behaviors with apparent suicidal intent – such as overdoses and self-poisonings – regardless of self-reported intent to die, are excluded from the NSSI definition.

Most researchers and scholars draw a clear distinction between behaviors where bodily injury is intended and those in which the injury is an unintended by-product. Most humans will

[2] The Child and Adolescent Self-harm in Europe (CASE) study was a seven year international research project funded by the European Commission Daphne Programme and coordinated by the National Children's Bureau. The project was completed in 2005.

engage in behaviors that can potentially lead to bodily or psychological harm during their lifetime, including alcohol consumption, eating unhealthy foods, smoking, driving recklessly and skydiving. These behaviors are not performed with the intention to cause harm however, and are typically not referred to as self-harm, but are more often labeled self-defeating, risky or simply unhealthy behaviors (Nock, 2010).

Self-harm is not, at the time of writing, a stand-alone diagnosis in either the *ICD-10 classification of mental and behavioural disorders* (World Health Organization, 1992) or the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [DSM-IV-TR], 2000), but it has been proposed to be included in the DSM-5 as Non-Suicidal Self-Injury Syndrome (Plener & Fegert, 2012). There has been considerable discussion among clinicians and researchers whether it should be included or not regarding the evidence base and the implications it can have for assessment, treatment and prevention (Arensman & Keeley, 2012), and with a special concern that being labeled "non-suicidal" could prevent identification of those who are at risk for later suicide attempts.

1.1.2 Prevalence

It appears there are differences between boys and girls regarding prevalence at different age groups. A Finnish longitudinal study (Sourander et al., 2006) found that among 900 12-year-olds, 2.7% of the girls and 3.1% of the boys reported ideations or acts of DSH. When the children had become 15 years old, the number had increased to 12.6% of the girls and 4.6% of the boys. Similar findings were reported in a Korean longitudinal study where researchers compared parental reports of 1,857 children at age 7 to the children's self-report responses at age 14 (Shin et al., 2009). Deliberate self-harm behavior increased from 6.76% of the girls and 5.51% of the boys at age 7 to 10.51% of girls and 7.85% of boys at age 14. The prevalence rate of self-reported DSH and suicidal ideation increased dramatically from age 12 to age 15 among girls; this was not found for the boys.

In a community based study of 665 youth in the United States, the researchers found that 7.6% of third-graders (age 8-9), 4.0% of sixth-graders (age 11-12) and 12.7% of ninth-graders (age 14-15) reported NSSI engagement (Barrocas et al., 2012). Only for ninth-graders did girls report a significantly greater rate of NSSI engagement than boys, similar to what Sourander et al. (2006) found in the Finnish sample.

The methods of self-harm also seem to vary with age as well as between genders. In the study by Barrocas and colleagues (2012), most girls reported that they either cut or carved their skin, while boys reported that they hit themselves. The majority of the third- and sixth-graders reported hitting themselves, while most ninth-graders reported cutting and carving their skin. In addition, many youth reported other methods such as biting, pulling hair, running into walls and throwing their bodies into sharp objects. Summed up, it appears that for young children who self-harm, there are no large gender differences. Differences become more pronounced as children enter the teenage years whereupon females are more often found to engage in self-harm. In addition, girls seem to more often cut their skin while boys hit themselves, and younger children more often hit themselves, while older children cut their skin. These developmental trends are worth noting for personnel working with children in a school setting.

There are no studies reporting prevalence rates among Norwegian children. The CASE study (Madge et al., 2008) which included self-report questionnaires from 30,000 mostly 15- and 16-year-olds in Australia, Belgium, England, Hungary, Ireland, the Netherlands and Norway, found an average lifetime prevalence estimate of 7.3% for non-suicidal self-injury in their entire sample. For the 3,838 Norwegian adolescents, lifetime prevalence rates were 4.3% for males and 13.5% for females respectively. As for the average age of onset of NSSI, a meta-study done by Jacobson and Gould (2007) found this to be between 12 and 14 years.

The difference in assessment methodologies and definitions combined with the short time period self-harm has been scientifically studied makes it difficult to conclude whether self-harm among youth is increasing. Anecdotal data from clinicians, teachers, and other health professionals however suggests an increasing number of cases, and hospital admissions for incidents of nonlethal self-injury show a heightened trend in the past 10-20 years (Nock, 2010). Jacobson and Gould (2007) tentatively suggest that NSSI may be on the rise based on their review of recent studies, but warn that further research – preferably of a nationally representative sample – is needed to support this conclusion.

1.2 Etiology of self-harm

1.2.1 Risk factors and correlates of self-harm

Most studies of risk factors and correlates have adult or adolescent samples. Age itself seems to be a risk factor; in a study of 150 mental health inpatients, those aged 11 and above were ten times more likely to have self-harmed than those aged 10 and under (de Kloet et al., 2011). This discrepancy must be interpreted with caution, considering factors possibly contributing to underreporting of self-harm among children. Such factors may include the presumption that young children do not self-harm combined with a general lack of knowledge and awareness of self-harm methods common to this age group (Simm et al., 2008).

Preliminary findings suggest differences between children and adolescents/adults regarding gender distribution (Barrocas et al., 2012; Sourander et al., 2006) and rates of depression (Meltzer, Harrington, Goodman & Jenkins, 2001). In a sample of 5,771 children aged 5-10 years, Meltzer et al. (2001) found self-harm to correlate with poor or "unhealthy" family functioning, increased number of stressful life events, physical complaints like speech and language problems, difficulties with co-ordination, epilepsy and soiling, special educational needs and specific learning difficulties. Self-harm was also independently associated with several different mental disorders. Rates increased from 0.8% in children with no mental disorder to 6.2% in those diagnosed with an anxiety disorder and 7.5% of those diagnosed with conduct disorder, hyperkinetic disorder or less common mental disorders like autism and tics. Surprisingly, according to parental reports, none of the children diagnosed with depressive disorders had ever self-harmed, contrasting with findings among adults and adolescents (Gollust, Eisenberg & Golberstein, 2008; Jacobson & Gould, 2007).

Two smaller studies also give information on the topic of risk-factors for self-harm in children. Krishnakumar, Geeta and Riyaz (2011) conducted separate and joint interviews with 29 children aged 12 and below and their parents. The children had been referred to a psychiatric unit due to self-harm. They found that in 90% of the cases, some kind of stress leading to the self-harm was present, including conflict with parents, conflict with siblings, parental disharmony, family history of mental illness, death of one or both parents, parental alcoholism, learning problems and conflict with teachers or peers. Moreover, 15 of the children had some kind of psychiatric disorder according to DSM-IV criteria; six had conduct

disorder, two had ADHD and different from what was found by Meltzer and colleagues (2001), 11 had a depressive disorder.

Simm, Roen and Daiches (2010) present anecdotal data regarding causes and triggers of self-harm in children, obtained from interviews with 15 primary school staff members. They found that staff often ascribed self-harm to difficulties at home, at school, in the peer group, or with regard to mental health issues. Stressors included falling out with a peer, parental relationship breakdown, emotional/sexual/physical abuse, poor parenting, feeling frustrated, angry, unhappy or unloved, low self-esteem, peer pressure, copying another person, and/or family problems of financial, social or emotional nature.

Neurobiological factors of self-harm in children have not been studied, and among adolescents and adults they are poorly understood. Studies of adolescents and adults suggest increased stress vulnerability due to abnormalities in neurotransmitters like serotonin, dopamine, cortisol and endogenous opioids (Groschwitz & Plener, 2012). Several findings suggest that self-harm may serve stress-regulatory purposes. Hyper-arousal of limbic structures and physiological tension decrease when imagining or performing acts of self-harm. Release of endogenous opioids during acts of self-harm provides pain analgesia and feelings of euphoria, which can serve as positive reinforcement (Groschwitz & Plener, 2012). The role of endogenous opioids points towards a possibly addictive nature of self-harm, which is supported by findings made by Nixon, Cloutier and Aggarwal (2002). That self-harm can be effective in regulating stress as well as having a potentially addictive quality speaks for the importance of early intervention, so that children can learn alternative and more adaptive coping mechanisms to manage stress before self-harm becomes a habitual response.

Studies have further linked self-harm in adolescents with negative developmental trajectories including engagement in negative risk behaviors, for example smoking, sexual risk behaviors, alcohol abuse, illicit drug use, recklessness and/or bulimic behavior (Brown, Houck, Hadley & Lescano, 2005; Favazza, DeRosear, Conterio, 1989; Guertin, Lloyd-Richardson, Spirito, Donaldson & Boergers, 2001; Llaye-Gindhu & Schonert-Reichl, 2005). Self-harm has also been related to suicidal ideation and suicide attempts (Garrison et al., 1993; Llaye-Gindhu & Schonert-Reichl, 2005; Nada-Raja, Skegg, Langley, Morrison & Sowerby, 2004; Nock, Joiner, Gordon, Lloyd-Richardson & Prinstein, 2006). The correlations between self-harm and undesirable developmental trajectories further underline the importance of early prevention and intervention.

1.2.2 Social learning of self-harm

According to Albert Bandura's influential theory of social learning (1977), people learn by observing others' behaviors, attitudes and behavior outcomes. The person observing has to attend to, encode and later reproduce the behavior of a model. When imitation occurs, the environment will react in ways that might serve either as reinforcers (increased probability of the repetition of behavior) or punishers (decreased probability of the repetition of the behavior). Such effects may also arise through vicarious reinforcement, which is the observation of consequences experienced by others.

The question arises whether observational learning could apply to self-injury. Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen and Helenius (1998) found that self-harm presented in a non-random fashion over a 12-month period in an adolescent psychiatric ward in Finland. 37 out of a total of 64 actions were regarded as a result of modeling. Six adolescents perceived as having been involved in two or more modeling incidents were later interviewed. Five of them identified feelings of group cohesion and togetherness to be a contributing factor to the self-harming behavior. Two denied feeling any relief of anger or anxiety as a consequence of such actions, and reported the main reason for self-harming to be to avoid feeling as outsiders. It is noteworthy that two of the subjects involved in the modeling episodes had never self-harmed before. These two were also the youngest, which may suggest increased vulnerability of young people faced with self-harm.

Other studies in psychiatric wards have also suggested that people may self-harm as a result of social modeling (Matthews, 1968; Nock & Prinstein, 2005; Rosen & Walsh, 1989; Walsh & Rosen, 1985), while two studies found no such effect (Cawthorpe, Somers, Wilkes & Phil, 2003; King et al., 1995). Moreover, some community-based studies provide indirect evidence for a social learning effect of self-harm (Alfonso & Kaur, 2012; De Leo & Heller, 2004; Hawton, Rodham, Evans & Weatherall, 2002; Muehlenkamp, Hoff, Licht, Azure & Hasenzahl, 2008; O'Connor, Rasmussen, Miles & Hawton, 2009). One questionnaire-based study of 6,020 adolescents suggested that whether self-harm is prone to social learning effects may depend on factors like type of self-harming behavior and gender (Hawton, Harriss & Rodham, 2010).

There are also a few studies suggesting social learning effects among children. Krishnakumar and colleagues (2011) found that five of the children in their study had learned about suicidal

behavior from real life models, two from newspapers and seven through television. One child had learned of a method from a relative, which she later tried. A Canadian study found children as young as 7 years old to have been part of a local “epidemic” of risky choking games in the form of self-strangulation by hanging from continuous cloth towels. Four of these incidents were fatal (Le & Macnab, 2001).

Easily accessible information available on the internet, television and magazines can give children ideas of ways to behave, which they may consequently try out. Dissemination over the internet has been discussed as a possible reason for the rapid spread of self-harm (Plener & Fegert, 2012). Lewis, Heath, St Denis and Noble (2011) used You Tube’s search engine and the keywords “self-injury” and “self-harm”. They found that videos containing self-harm material were largely educational (53%) or melancholic (51%), and that explicit imagery was common. Over half of the videos had no prior warning of the content or viewer restrictions. Such material can normalize self-harm and serve as reinforcement of the behavior. The authors argue that parents and teachers can benefit from knowledge of these videos, which may lead to more open and informed discussions about self-harm with young people.

1.3 Functions of self-harm

Many would react with fear, disgust, hostility and revulsion when encountering people who intentionally afflict pain and injury onto their own body (Muehlenkamp, 2005). The notion that harming oneself can be self-soothing may be incomprehensible to those unfamiliar with the phenomenon. Babiker and Arnold (1997) point out however that self-harm may serve as a strategy to stay alive: “The person who self-mutilates can be said in some ways to be carrying out the very reverse of self-destructiveness. They are seeking to preserve themselves. Rather than wishing to destroy themselves, their self-injury helps them to stay ’together’, to struggle to survive” (p. 7). Animals, for instance macaque monkeys, are known to injure themselves under severe stress, especially when kept in solitary captivity, hence the assumption that there must be some kind of reward for the individual engaging in these behaviors.

Research indicates that there are complex emotional processes involved in those who self-harm. For most individuals who engage in self-injurious behavior, psychological experiences of increasing tension, anger, anxiety, dysphoria, general distress or depersonalization which the person feels he or she cannot escape from or control often precedes the act of self-injury

(Muehlenkamp, 2005). The act of self-injury is subsequently followed by an immediate sense of relief, gratification and release from depersonalization which serves to strengthen the behavior (Muehlenkamp, 2005). Jacobson & Gould (2007) found that adolescents feel a combination of relief, shame, guilt and disappointment in the aftermath of self-injury. Furthermore, most adolescents who engage in NSSI do so impulsively, while sober, and experience little to no pain under the act (Jacobson & Gould, 2007).

Dow (2004) investigated findings based on an analysis of children calling the 24-hour telephone helpline *ChildLine* between April 2002 and March 2003. Of the 120,000 children counseled, 3,345 children aged from 5 to 18 talked to ChildLine about self-harm. Two main themes emerged. Firstly, callers disclosed anger and frustration at their situation, with self-harm providing the only outlet for their emotions. Secondly, children talked about a loss of control over their lives, and by inflicting injury they could regain a sense of control and ownership. This supports the hypothesis that self-injury is used as a means for emotion regulation. In 2011, over 16,000 children contacted ChildLine with worries about self-harm, an increase of 68% from 2010/11. As a result, Sue Minto, the head of the charity, called for a shut-down of websites that promote and glamorize self-harm (Johnson, 2012).

In the previously mentioned study by Simm and colleagues (2010), school staff ascribed several different functions they thought self-harm could serve for children. Examples included a means to take control or to release negative feelings, and a way to distract or comfort oneself. Self-harm was further seen as a potential means for attaining something; either as a cry for help or to manipulate others. Some staff members also trivialized the self-harm, saying that it stemmed from either peer pressure, showing off, habit, boredom or experimentation.

From a functional perspective, Nock (2010) proposed a four function model where self-injury is maintained via four possible reinforcement processes. These differ based on whether the reinforcement process is positive or negative, and whether the consequent events are intrapersonal (automatic) or interpersonal (social). One of the most consistent maintaining factors relating to NSSI among adolescents is automatic negative reinforcement (Jacobson & Gould, 2007). This means that the self-injurious behavior is maintained through its effective termination of the aversive state which the individual is experiencing, for example relief of tension from anger, anxiety, dysphoria or depersonalization. Some adolescents endorse engaging in NSSI for automatic positive reinforcement, which occurs when a behavior is strengthened as a consequence of some kind of stimulation that is not mediated by another

person, for example prompting feelings when none exist. Yet others report doing it for social positive reinforcement as means for eliciting attention or support and social negative reinforcement (to remove social responsibilities, to stop peers from bullying).

1.4 Prevention of self-harm at school

Several research articles comment on benefits of schools as an arena for prevention and intervention regarding self-harm. Schools may play important roles in offering help both directly and by acting as liaisons to other professionals, hereby facilitating connections with prosocial adults (Wilkinson, 2011). Through various programs, such as promoting emotional literacy or focusing on mental health, schools provide an excellent stage for early prevention of childhood problems (Alfonso & Kaur, 2012; Hawton et al., 2002; O'Connor et al., 2009, 2009; Taliferro, Muehlenkamp, Borowsky, McMorris & Kugler, 2012). The following section focuses on elementary schools' potential contributions to providing help to children who self-harm. We introduce mental health policies in Norwegian elementary schools, followed by research on the relationship between knowledge of self-harm and helping behavior in staff. Lastly, there is a discussion of the possible roles of school staff regarding children's wellbeing, as well as a summary of findings from a previous study on primary school staff's experiences and understandings of children who self-harm in the UK.

1.4.1 Mental health policies in Norwegian elementary schools

We will introduce the Norwegian school system through presentation of the *Educational Act* (Opplæringslova, 1998) and the *Knowledge Promotion* (Utdanningsdirektoratet, n.d.a), with particular emphasis on aspects relevant for children's psychological health.

Norwegian primary and secondary school pupils' rights are regulated through the Educational Act (Opplæringslova, 1998). Chapter 9a describes pupils' school environment, with paramount requirements described in §9a-1: "All pupils in primary and secondary schools have the right to a good physical and psychosocial environment that promotes health, well-being and learning". §22-2 of the Educational Act (Forskrift til opplæringslova, 2006) states that "the individual pupil has the right to receive counsel regarding social issues", while §22-4 states that such counseling shall be offered by "staff with relevant competence". There is no specification of what kind of competence is required, nor is there a requirement that

elementary schools must employ someone to specifically manage these tasks. As a consequence, many Norwegian elementary schools integrate this work into the teachers' and/or school leadership's roles. According to a report published by Utdanningsforbundet (2011), the ratio of school counselors to teaching personnel is low in elementary schools compared to secondary schools (4 per 1,000 versus 3 per 100 respectively), reflecting the fact that municipalities of Norway are required to hire someone for this position in secondary schools, but not elementary schools. This may be grounded in an assumption that young children experience less distress than teenagers and are thus less in need of a dedicated school counselor at their school.

The Knowledge Promotion gives a comprehensive coverage of goals and methods for children's professional development. In addition, it describes goals for the development of social skills and contains requirements regarding preventive and health-promoting work in schools, reflecting the requirements of the Educational Act. The development of social skills is expected to be an integrated part of education (Utdanningsdirektoratet, n.d.b). The Knowledge Promotion does not suggest specific methods to attain these goals; this is left to each individual school and teacher to decide. *The Norwegian Directorate for Education and Training* has published a guide that suggests methods for building social skills at school, at both class and individual levels (Utdanningsdirektoratet, n.d.b.). It also contributes a list of evidence-based programs with clear guidelines for implementation to promote the development of social skills and a good environment at school.

In contrast to the emphasis on psychological well-being in schools, direct talk about psychological problems, including self-harm, seems to be avoided or to be considered a topic better suited for higher grade students (Utdanningsdirektoratet, 2010). We were unable to find guidelines regarding such issues for elementary schools.

1.4.2 Knowledge and helping behavior in staff

Turp (1999) suggested that the issue of self-harm should be seen as a relevant area for several professions because children and adolescents who self-harm may be referred to or receive help from a variety of professionals within the school system, including general practitioners, social workers and psychologists. There is a need to investigate the knowledge and understandings that school staff have of self-harm behavior in children, as negative attributions may affect the help youth receive. Meyer & Mulherin (1980) found that adults

who perceived the cause of another's distress to stem from controllable factors report relatively higher anger and disgust coupled with low sympathy and are less likely to help the victim. This was opposed to an individual whose need was judged as uncontrollable which tended to evoke sympathy, offering to help and relatively little anger. Thus, helpers who perceive self-harm behaviors as avoidable and "unnecessary" may meet the child with unhelpful attitudes and withhold help.

There are several British studies investigating attitudes among helpers who work with youth who self-harm. Friedman et al. (2006) investigated the influence of previous training and experience among accident and emergency (A&E) staff and found that they generally felt unskilled in dealing with the youths who present with self-harm behavior. Most of the staff acknowledged the notion that self-harm by cutting was associated with distress, but almost 80% felt it was also about "seeking attention", which the authors say was linked with the idea of patients being manipulative rather than appropriately seeking medical attention. For staff that had not received training on self-harm, there was a relationship between increased years of experience and negative attitudes. The negative experiences of self-harm patients in their encounters with A&E staff are illustrated in Harris (2000) "I was told off by nurses and the doctors. I just felt small. They do treat self-harmers different to accident people. We are classed as suicides... The hospital staff just look at you as though you're wasting their time. That's how I felt" (p. 168). If youth who self-harm are met by condemnation and negative judgment by helpers, be it at school or elsewhere, they may feel humiliated and become even more self-loathing, which can lead to an increase in their self-harm behavior.

The relationship between knowledge of self-harm and attitudes among A&E staff, Child & Adolescent Mental Health Services (CAMHS) staff and secondary school teacher staff was investigated by Timson, Priest and Clark-Carter (2012). They found a significant relationship within all three groups between negative attitudes (expressed towards patients or family) and poor knowledge. The more negatively they felt, the less knowledgeable they perceived themselves to be. Staff members who are knowledgeable about adolescent self-harm feel more effective in their work and less negative, which supports the notion of providing better information to multi-disciplinary staff. None of the teachers in this study had received training on self-harm, and they reported that they would benefit from further training, knowledge and supervision. The authors also found that when staff felt more effective, they felt less negative dealing with these clients. Crawford, Geraghty, Street and Simonoff (2003) reported no

relationship between attitudes and knowledge, but found that health professionals who felt more effective also felt less negative towards this group of patients. Greater awareness of the distress self-harm causes may make staff feel more confident and empathic when working with children who self-harm which can promote de-stigmatization, leading to more positive behavioral responses. Additional training on how to manage children who self-harm will likely lead to more confident staff and make them more positive in dealing with these children.

1.4.3 School staff and children's wellbeing

Staff employed as school counselors have hours specifically earmarked for taking care of children's wellbeing through individual conversations with the child and implementation of preventive work. Most staff in the school system do not have this opportunity, as their days are filled up with teaching hours. In contrast to middle- and high schools, teachers at the elementary school level in Norway have limited free time outside lecturing hours. In addition, the pupil-teacher ratio, although varying from school to school, is often high. Kunnskapsdepartementet (2009) reports the mean number of pupils per teacher to be 13.12 for first to fourth graders and 16.84 for first to 10th graders. It is not unusual to teach classes of up to 30 pupils alone, with no opportunity to call on a substitute if a pupil needs time alone with the teacher. Such constraints are likely to come into conflict with the desire to give children the individual attention, time and care that they need.

A Finnish study (Rissanen, Kylmä & Laukkanen, 2009) collected written descriptions provided by 62 adolescents who self-harm (12-21-years-olds) of the help they received and wished to receive. Both teachers and school counselors were identified as potential helpers, and it was found that youth wished to be directed to the school nurse and that they desired that staff would ask them about the self-harm. The youth were of the opinion that adults have a duty to help, but that school and healthcare personnel did not intervene. The authors stressed the need for personnel to have some knowledge of self-harm as a phenomenon and to intervene every time by asking the adolescent about suspicious wounds, marks or scars.

School personnel have certain advantages when it comes to playing part in children's psychological wellbeing. Teachers have the opportunity to build close relationships with children in their class. They can observe the children in both structured and unstructured situations over time, providing good opportunity to detect a child in distress. The importance

of a positive student-teacher bond characterized by respect, seeing the individual child and displaying interest for the child's interest is emphasized by the Norwegian Directorate for Education and Training (Utdanningsdirektoratet, 2009). Psychotherapy outcome research explores the relationship between client progress and so-called common factors that are found across various therapies. Therapist effects important for change are related to the client's perceptions of the therapist's empathic understanding, the degree to which the therapist is successful in communicating personal comprehension of the client's experience; positive regard, the extent to which the therapist communicates non-evaluative caring and respect; and congruence, the extent to which the therapist is non-defensive, real and not "phony" (Lambert & Barley, 2001; Patterson, 1984). Although not expected to provide in-depth therapy, we believe that school staff that possess these qualities can make a difference when working with children who present with self-harm and that they can act as liaisons for further interventions if necessary.

1.4.4 Related studies

A study similar to the current one was done by Simm and colleagues (2010) in the UK. The authors conducted interviews with elementary school professionals investigating their responses to self-harm among children. 15 staff members from six schools were interviewed, exploring how self-harm affects staff emotionally; reasons staff ascribe to children's self-harm and how self-harm was managed. The researchers found that all participants experienced negative feelings when working with a child who self-harmed. They talked about feeling scared, shocked, panicked, sad and distressed. Frustration due to feeling that they were not helping the child and did not know what to do was also reported, with the desire to direct the child to someone with a higher expertise than what they possessed themselves. Negative feelings were managed by discussing them with a supportive other, by repressing the feelings or by seeking further training. Previous training around self-harm was greatly valued by those who had received it.

How the staff attributed the self-harm influenced how the behavior was managed in school. If a child's self-harming was seen as "bad behavior" with the primary goal to annoy the teacher, the child was consequently punished. If the behavior was attributed as self-harming, the learning mentor would believe the child needed help rather than punishment as it was considered that the child had experienced something he or she could not express verbally. If

the child was considered to be in need for help, the child would usually be referred to the school's learning mentor, and information was gathered to help understand why the child was resorting to self-harm. The issue would initially be dealt with in school, and referred to outside agencies if deemed necessary. Restraining, calming and comforting the child and allowing space and time to talk were mentioned as useful interventions by staff members.

At neither school was self-harm talked about as an educational topic, but could be alluded to in the Personal Health and Social Education curriculum which had a module about "taking care of ourselves". Learning mentors and teaching and support assistants felt that self-harm should be talked about with children as a means for prevention, while teachers and head teachers felt that it should not be talked about unless a child made it visible, and some feared a learning effect should the topic be made more visible to children. Furthermore, head teachers felt that self-harm should not be prioritized as it was a low-prevalence problem.

1.5 The aim of this study

The aim of this study was to explore the experiences, perceptions and recollections of elementary school staff in their encounters with young children who self-harm. By conducting interviews with staff in the Norwegian school system we hoped to gain insight into their personal understanding and how they make sense of self-harm among elementary school children. We were aiming to explore the potential role elementary schools can serve in promoting children's mental health in general and discovering self-harm in particular. In addition, we wished to investigate whether the topic of self-harm was seen as something that can be discussed with children or if this was deemed "dangerous". Finally, we wanted to understand the interviewees' experiences of self-harm in elementary schools, exploring the types of behaviors that are most often understood as self-harm, types of behaviors they had observed, how they came to know of the self-harm and their beliefs on the functions, causes and triggers of self-harm in young children.

By conducting this study we are hoping to increase awareness about self-harm among young children, to inspire further research in the field, to empower school staff to believe they can make a difference and to encourage changes in the school system regarding children and self-harm.

2 Method

This study is an independent research project which received no funding. All the data presented henceforth were collected by the two authors. Procedures, participant demographics as well as methodological and ethical considerations are reviewed in the following section.

2.1 Ontological and epistemological considerations

The analysis was informed both by the thematic approach and *Interpretative Phenomenological Analysis* (IPA). IPA aims to explore in detail how participants make sense of their world and experiences as opposed to the attempt to make an objective statement of the object or event itself. IPA has roots in phenomenology and symbolic interactionism, but has been developed in the last few years as a distinctive approach to conducting empirical research, and has gathered considerable interest among psychologists (Chapman & Smith, 2002). Phenomenological methods combined with an interpretive account can enable it to be used as a basis for theory (Lester, 1999), arguably even more so in areas of interest with little pre-existing research, as is the case with elementary school children and self-harm.

With IPA one utilizes an explorative style to gain access to the meanings and reality of the informants, while at the same time acknowledging that the research process is dynamic and will be guided and influenced by the active role of the researchers. One cannot gain complete access to the participant's inner world; this can only be done indirectly or incompletely (Smith & Osborn, 2008). In the interpretive process, the researcher's own conceptions will influence how he or she makes sense of the participants' personal domain. The researcher strives to make sense of the participants' own attempts to understand their world while at the same time allowing for the asking of critical questions from the text. The researcher may for example have a sense of something going on that the participants themselves are not aware of, or the researcher may make inferences as to what the person is trying to achieve (Smith & Osborn, 2008).

We strived to maintain a curious and explorative style during the interviews to promote a good level of rapport and empathy with the participants, as this can facilitate gaining depth of information. We did not set out with an initial hypothesis, but we did record field notes and salient ideas after every interview session.

2.1.1 Trustworthiness

What counts as a theme in qualitative research is influenced by the judgment of the researcher. There is no single set of categories or themes just waiting to be discovered (Ryan & Bernard, 2003). Themes do not merely "emerge" from the data set, but are actively identified and reported by the researcher (Braun & Clarke, 2006). Even so, the process of finding themes is not solely based on the researcher's whims; it must be anchored in the data. Therefore, it is essential that the selection of themes is made transparent by illustrating them with relevant extracts from the interviews. If the judgments and reasoning of the researchers are made clear, the readers can make up their own minds and argue with the researchers' conclusions (Ryan & Bernard, 2003).

We used two coders working separately with the data which provides an added degree of trustworthiness. This is important in that it indicates that the coders are measuring the same thing (Ryan & Bernard, 2003). We ended up with largely the same codes and sub-themes, which further demonstrate that the final themes are not mere figments of the researchers' imagination, which adds to the likelihood that a theme is valid.

It is important to distinguish between statistical and qualitative validity in multi-participant research. The interview sample of this study consisted of 12 interviews which were conducted with 15 staff members where all had some degree of experience with children who self-harm. Trends in the data encountered through coding for salient themes can indicate the presence of factors that can generate theories for later research, but one must be tentative in generalizing to the population from which the participants were drawn (Lester, 1999). This ideographic style of inquiry contrasts with nomothetic research where analysis of representative groups can allow for statistical and probabilistic claims about individuals (Smith & Osborn, 2008). We instead strive to illustrate in detail the perceptions and understandings of the group of participants, which may lead to more general claims as subsequent studies are conducted. The current study however also includes a larger sample of participants (n=63) who answered an online survey, adding some strength to the findings. One limitation to this study is that the authors are not experienced in the art of interviewing. Flick (2002) suggests interview training to enhance reliability by doing test interviews that allow for adjustment of the interview questions. We interviewed two friends and a fellow psychology student before beginning the interview process and made some changes based on that feedback. We acknowledge that lack

of prior interview training may have affected the depth of the interviews as well as the level of richness in the data.

2.1.2 Language and translation

Both the informants and the researchers in this study have Norwegian as their primary language. Interviews, transcriptions and analysis were done in Norwegian. Interpretation of meaning is the core principle of qualitative research, and it is fair to ask whether translation from one language to another may consequently lead to meaning getting lost, as translation itself is an interpretive process. Concepts in one language may have different meanings in another language, especially when cultural contexts differ (Van Nes, Abma, Jonsson & Deeg, 2010). In this study, no challenges were present in the data gathering phase, nor in analyzing the data itself, as this was all done in Norwegian. The challenge arises with the translation of the quotations that are used to illustrate the themes of interest. Using more words than what was present in the original quotation changes the voice of the participant and care must be taken not to remove or add words that can change the original meaning provided by the informant. To reduce the chance of meaning being lost, we back-translated the English extracts to Norwegian, checking whether the original meaning remained the same. We also had a native English speaking supervisor we could consult if we were in doubt regarding subtle meaning differences between the languages.

2.2 Procedure

2.2.1 Developing the online survey

We began the process of developing the online survey by reading self-harm literature. Based on that and our own ideas, we wrote down preliminary questions relevant to capturing people's experiences, perceptions and recollections of self-harm among elementary school children. Next, we took a closer look at each question, trying to answer them ourselves to get an impression of whether they were worded in an easily understandable way, whether they would be easy to answer and whether they had the potential to generate rich responses. The next step entailed asking a few people, including a school teacher, to answer the questionnaire to check for any confusion or bad wording. Changes were made based on their feedback. The

layout and the questions were finally reviewed by a senior advisor who has some experience with development of surveys. For the final questionnaire, see appendix A.

The subjects were allowed to see the definition of self-harm from the CASE study (Madge et al., 2008). We had two reasons for this choice. Firstly, we would not get the opportunity to explore the survey respondent's answers in the same manner as through the interviews. Secondly, the survey sample was larger. We saw this as an opportunity to get a comprehensive list of actions the subjects had seen or heard about and could think of as self-harm. Through giving them the definition in the start of the questionnaire we were aiming to encourage them to reconsider their responses, and maybe come up with more examples of self-harm than if not given the definition.

A letter with a short description of the research subject and information about anonymity and approval from NSD was sent by e-mail to the principal of elementary schools (appendix B), or to the administration in the cases we could not find the principal's e-mail address. The letter contained a direct link to the online questionnaire. The recipients were encouraged to forward the letter to their teaching staff. The e-mail was initially sent to all 99 elementary schools of Oslo, special needs schools excluded. We received only two responses to the questionnaire in one week, so we decided to expand to more counties. We found the internet pages of several municipalities and collected the e-mail addresses of their respective elementary schools. The questionnaire was sent to a total of 909 additional schools across the country. We sent the schools a reminder within a month of the first e-mail, this time asking them to reply whether they had forwarded the e-mail or not. We got a total of 23 responses to this (8 positive and 15 negative), a small number compared to the total of 1008 schools. Ultimately, there is no way we can learn the number of schools who forwarded the e-mail and the response rate is left unknown. We got an impression that several school administrators actively shielded their employees against extra work, as they were already hard pressed on time. The recruitment process gave a total of 63 replies to the questionnaire.

2.2.2 Developing the interview guide

We got a good overview of topics we would like to investigate more thoroughly after developing the online survey. We made an interview guide with questions that provided an overview of the thematic areas to be covered, as suggested by Kvale (2007). This was used as background for developing the questions that would be used in the interviews. We worked on

the wording of these questions to make sure they were expressed in an understandable, everyday language, and to get a feeling of what kind of questions that would invite interviewees to give detailed accounts about their own experiences and thoughts (Kvale, 2007). The interviews were semi-structured, so the guide was not meant to be irrevocable. In the semi-structured interview, the interviewer seeks to obtain rich descriptions of the interviewees' experience on the topic of interest. Interviewer questions are used to guide the conversation, but the interviewer is free to diverge from the guide to explore relevant information more deeply. An open approach like this creates an opportunity to let the interview develop in the present moment, with the questioning being guided by the interviewer's knowledge, interviewing skills and intuition of where to go next (Kvale, 2007). Conducting the whole interview with two friends and a fellow psychology student provided feedback that led to final adjustments on the wording of the questions. The interview guide is included as appendix C.

2.2.3 Conducting the interviews

We decided to conduct the interviews together. We discussed the possibility of one of us having the leading role throughout the interviews, perhaps alternating roles between interviews, but eventually ended up with sharing the interviewer role so that both were free to ask questions throughout the interview. Before the start of the interview the participants were asked to read the information letter, if they had not yet done so. They were informed about the use of the voice recorder, confidentiality, anonymizing of the data and about the possibility of opting out from the study any time during the course of the interview. If the interviewee had no further questions, he or she was asked to sign a letter of informed consent (appendix D), and the recorder was turned on. As described above, we had an open and curious approach hoping to get narratives affected as little as possible by our prior thoughts and assumptions (Kvale, 2007). We were sometimes asked to provide our own thoughts, which we shared tentatively and with the emphasis that we had no blueprint answers to any of the topics discussed, whereupon we returned the question to the participant. We decided not to give the interviewees a definition of self-harm. This would allow us to get a better impression of the interviewees' personal understanding.

2.2.4 Transcribing the interviews

After finishing an interview, an audio file was transferred to a computer and permanently deleted from the recorder. After all the interviews had been completed, we transcribed six interviews each. We were not aiming to do an analysis that would require going down to the linguistic level of the interviews. We wrote down the interviews word by word but excluded "mh"-s and the like, and did not note pauses or bursts of laughter (Kvale, 2007). Transcripts are useful tools when conducting qualitative analysis, but they are not direct translations of spoken stories into written form. Contextual information is necessarily lost throughout the transcription process, which must be kept in mind by the researchers (Kvale, 2007).

2.3 Participants

At the bottom of the online survey we included an encouragement to contact us for an in-depth interview. We intended to ask interested participants to leave their contact information in the questionnaire, which would have enabled us to contact them directly. This would have been less demanding for the participants, and could have increased the response rate. Because of ethical concerns about the possibility of linking answers with identifying data, NSD could not approve of this approach. We instead asked respondents to send us an e-mail if they wished to participate in an in-depth interview on the subject of elementary school children and self-harm.

Nobody contacted us based on this encouragement, so we started contacting schools by showing up in person. We started out by contacting a few schools in Oslo proper, but realized that we would probably have greater success by going beyond the city border. Schools in Oslo experience great demand from students and media wanting schools to participate in various projects and surveys. This pressure is probably less outside Oslo. Participants were recruited through direct contact with 27 schools located in five counties in Eastern Norway. One school was called directly due to one of the author's (AKS) being an acquaintance of the principal. We were told that they had experience with the problem, and the school counselor later called us back to make an appointment. The other 26 schools we visited in person and we inquired to speak with the principal. If he or she was not present, we conferred with the inspector, which is the deputy principal. The school administrator or principal was briefly introduced to the topic. We gave them a detailed information letter (appendix E) that they could convey to interested teachers, and we asked permission to contact teachers or school counselors working

at the school. We were welcomed at the majority of the schools and granted permission to contact staff directly. Several principals or deputy principals offered to copy the letter and circulate it within the school for staff to volunteer for interviews. A few principals explicitly stated that they would not make a direct request to their employees to participate in this study due to the heavy workload teachers are experiencing. We were told that interviews would have to be done on a volunteer basis. Furthermore, due to time constraints it might not have been possible to conduct the interviews during working hours, so if someone did volunteer, the interviews would probably have to take place after-hours. At some schools we managed to make an appointment on the spot, while other staff members contacted us after having read the information letter and given the offer some thought. We encountered a few schools where the principal was of the expressed opinion that the subject of elementary children who self-harm is so important that they personally encouraged the school counselor to participate within working hours.

2.3.1 Online survey

We received a total of 63 responses to the online survey. The respondents consisted of 55 females and 8 males. On several questions they were given the option to respond freely. We grouped staff into three over-arching categories regarding their position at school: 42 teachers, 13 principals/administrative leaders, and eight school staff with a specialization in pedagogy/school counselors. On the question of what grades they worked with on a daily basis, 57.1% answered first to third grade, 60.3% answered fourth to seventh grade, and 3.2% answered eighth to 10th grade. The respondents could reply that they worked with multiple classes, so the percentages do not add up to 100%. The age distribution of the respondents can be found in Figure 1. There was a good spread in the amount of years respondents had worked with children; see Figure 2 for details.

Figure 1: Age distribution of survey respondents

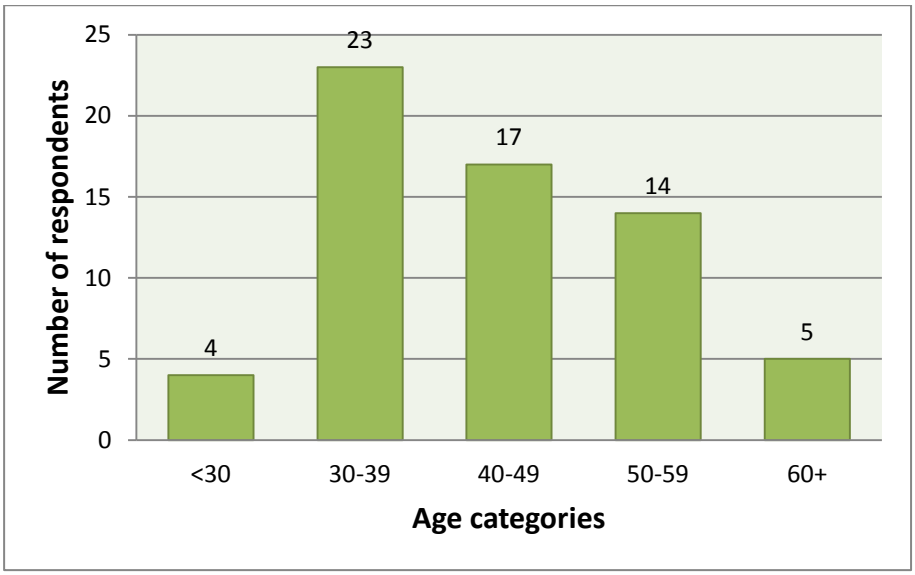
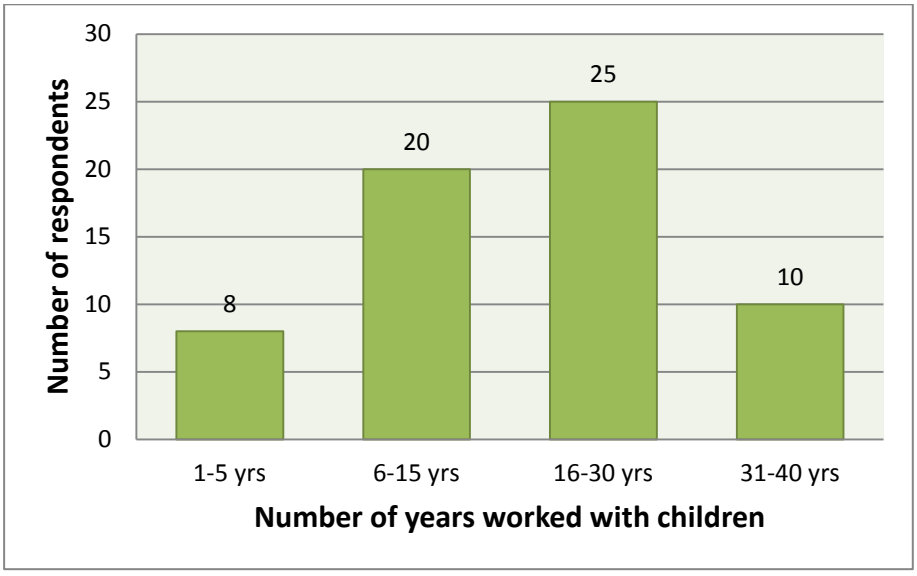


Figure 2: The amount of years survey respondents had worked with children



2.3.2 Interviews

We initially aimed at interviewing a diversity of school professionals, but ended up with the majority of interviewees being school counselors. The eventual sample consisted of ten school counselors, two teachers, one assistant teacher and two assistant principals who were also part-time school counselors, resulting in a total of 15 interview participants. School counselors in Norway have a special role of making pupils who face different hardships better adapt to the school environment. The broad range of problems that children may encounter at school or outside of school may relate to educational, personal or social domains. Most school

counselors have, in addition to the standard teacher education, expertise in pedagogy or special pedagogy. Some may also be educated as social workers. They serve as counselors and are responsible for the coordination with other departments such as the health services, BUP (child psychiatry services), child services or other local systems, should there be need for collaboration in working with a particular child. At several schools we were promptly introduced to the school counselors when we presented the project to the school principals as they were considered to be the group of professionals with most first-hand experience of children who self-harm.

2.3.3 Joint interviews

Six of the school counselors were interviewed in pairs. They expressed working closely together, cooperating on preventive work and sometimes on individual cases, changing responsibility for cases whenever necessary and using each other as support in difficult cases. From a Heideggerian standpoint it is argued that people make sense of their world from experiences within this world and not as detached, objective beings (Taylor & de Vocht, 2011). The presence of another person in the room during an interview can never be an objective one, whether the other person is an active part of the interview or not. This does not imply that one type of interview is better than the other, but that they will generate different types of data. The joint interview opens up the possibility to explore the two subjects' shared experiences and meanings. We get "their story" instead of their separate stories. The resulting narrative might be facilitated or constrained as compared to individual narratives. As a researcher, one will face the problem of not being able to predict in advance the type of effect the joint interview will have on the particular interview in question (Taylor & de Vocht, 2011). Dialogic theories stress the same type of interaction between interviewers and subjects. The interview with just one subject will be influenced by corresponding factors as the one with two subjects – that is by the speaker her/himself, the audience and the context (Bakhtin, 1986). Thus the interviewing of one versus two subjects will provide different data, but not necessarily deeper data (Morris, 2001). All of the subjects we interviewed in pairs themselves suggested the joint interviews. Within the frames presented here, and due to their very close working relationships, we chose to employ this approach. The nature of their relationship also made it natural for us to invite them to an equal level of participation throughout the interview (King & Horrocks, 2010).

When it comes to doing interviews with two researchers, Hove and Anda (2005) have evaluated experiences from twelve studies with a total of 280 semi-structured interviews as the data gathering tool. They report several advantages of being two as opposed to one interviewer. Two interviewers can lead to more questions being asked and consequently subjects talking more, with the result of more information being collected. In addition, it is difficult to listen closely to a story and at the same time come up with new questions. A fellow researcher can focus on what is said and aid with supplementing questions whenever necessary. Concerning the analysis, being two increases the probability of understanding the subjects correctly because it opens up the possibility to do double analysis and thereafter discuss the interpretations of the interviews. Disadvantages of being two may be the requirement of more planning. The interviewers must have a common understanding of where they want to head, so they will not pull in different directions during the course of the research (Hove & Anda, 2005).

2.4 Analysis

2.4.1 Analyzing the interviews, step by step

The analytic approach taken in this study was informed both by Interpretative Phenomenological Analysis (IPA) and thematic analysis. Braun and Clarke, (2006) describe thematic analysis as a "method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes the data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic" (p. 79).

Thematic analysis can guide the search for themes in two different ways; the inductive (data-driven) way, or in the deductive (theory-driven) way. The analysis of this study is closer to the inductive approach as the data were not coded to fit into a pre-existing coding frame and the research questions evolved throughout the coding process. We take on a realist perspective, aiming to report the experiences, meanings and reality of the interview subjects, while at the same time allowing for interpretations to be made in accordance with the IPA approach.

The analysis itself is an iterative process which revolves around the reading and re-reading of the interviews to familiarize oneself with the data. Each reading may provide new insights and perspectives. Writing down ideas and potential coding themes should be done from the start. We will describe how we analyzed the data in a step-by-step fashion, but as Braun and Clarke (2006) point out, analysis is not a linear process, but requires a back and forth movement between the steps. The analysis was heavily influenced Braun and Clarke's (2006) outline.

Step 1: Familiarizing oneself with the data

We conducted our own interviews which provided an excellent opportunity to familiarize ourselves with the data first-hand. It also allowed us to begin the analysis process with some initial thoughts or ideas formed during the interview process (Braun & Clarke, 2006). We transcribed all the interviews ourselves which further provided repetition of the material. Once the transcription was finalized, we read through the transcripts actively searching for interesting topics and meanings. We worked separately from each other at this step and made our own notes of interest.

Step 2: Generating initial codes

In this phase, we systematically worked our way through all the twelve interviews separately, thoroughly coding for anything of interest with the goal of including as much data as possible (Braun & Clarke, 2006). This was a coarse process where we ended up with a high amount of codes which were exemplified by extracts from the interviews. We did the analysis manually in Microsoft Word, with a separate coding sheet where we dragged-and-dropped relevant data extracts to their respective coding headlines. The extracts were marked with interview number to better illustrate whether it was a recurrent subject within or between the interviews. We were careful not to limit the extracts too much, and we strove to maintain the context surrounding what was said.

Step 3: Searching for themes

Once the coarse coding was done, we began the process of searching for themes. The initial step of finding themes was also done individually. We worked our way through all the codes, trying to find commonalities among them that would allow us to group them into more over-

arching themes. The goal of this pruning process was to try to find some main themes and sub-themes, while discarding others (Braun & Clarke, 2006). There is no set-in-stone answer to what qualifies as a theme, but it is desired that the theme captures something important in relation to the research question and represents some level of patterned response found throughout the interviews (Braun & Clarke, 2006). Prevalence of a theme may not mean that the theme is more important than a theme with fewer occurrences. How many repetitions are enough to constitute an important theme is an open question, and one only the investigator can decide (Ryan & Bernard, 2003). While searching for themes, it may be useful to ask how this text is different from the preceding text. Keeping a keen eye on what is missing may also provide useful insights; whether there are some topics that are intentionally or unintentionally avoided by the interviewees (Ryan & Bernard, 2003).

Step 4: Reviewing themes

This is a refinement stage where the initial themes are reviewed in detail. Some themes may not have the data to support them and will thus be discarded. Others may be too similar and can be combined, while others again may be too broad and can be split into separate parts. A theme should cohere internally, while at the same time being distinguishable from the other themes (Braun & Clarke, 2006). We worked together at this stage, compared our previous codes and agreed upon four over-arching themes which incorporated the majority of the coded extracts that we had found separately from each other. Extracts that did not fit into these themes were discarded. With the four candidate themes in mind, we re-read the entire data set, to ascertain whether the themes reflected the essence of the data, and also coding extracts that might have been left out in earlier coding stages (Braun & Clarke, 2006).

Step 5: Defining and naming themes

This step entails finding out what each theme is really about, as well as what they tell about the data overall (Braun & Clarke, 2006). The goal is to end up with themes that are not too broad and complex, and to identify what is of interest in the data extracts belonging to each theme. Each theme should tell a story that will eventually be fitted into the overall narrative that the whole of the data set provides in relation to the research question (Braun & Clarke, 2006). One must decide whether a theme consists of potential sub-themes if the theme itself is particularly complex. At the end of this stage, one should be able to clearly describe each

theme in the space of a few sentences. If this cannot be easily done, the refinement process should continue. The name of each theme should provide the reader with a good sense of what the theme is about (Braun & Clarke, 2006). We ended up with three over-arching themes, each consisting of sub-themes.

2.4.2 Analyzing the online survey

The analysis of the online survey was done by grouping the respondent's answers into the same or similar categories that we used for the interviews. This enabled the comparison of similarities and differences between the two data sets. Several of the replies regarding the understanding of self-harm were written freely by the participants without any predetermined categories. A two-tailed chi-square test was done to test differences on categorical data. We do however assume a pronounced bias in the response rates, with individuals having experience with self-harm being more likely to reply compared to individuals who have not given the subject any previous thought.

2.5 Ethical considerations

Online survey participants were informed that their answers would be used for research purposes. They were asked not to give identifying information about themselves or pupils, and were required to agree to participate. Interviewees signed a letter of consent and were reminded of the importance of protecting the children's confidentiality when telling about their experiences. They were informed that if identifying information was revealed during the interview, we would later remove such information when transcribing. The interview was recorded on a Sony Voice Recorder, the memory of which was wiped after the interview was transcribed. The audio files were accessed only by the two authors. Place names, participant names, colleague names and other information that could be used to identify municipality, county, school or origin of the child were removed in the transcripts. Dialects were transcribed into neutral form to further anonymize the participant. The project was reported to and approved by Norsk Samfunnsvitenskapelige Datatjeneste (NSD), see appendix F. The majority of participants said that it was interesting to be part of the interviews and that it generated some novel thoughts on the subject. None reported any aversive effects of participating.

3 Results and discussion

We wanted to investigate what elementary school staff associate with self-harm behaviors in elementary school children; whether they had first-hand experience with children who self-harm, how they came to know about a particular child who self-harmed, how they perceived their own efficacy in their efforts to help these children and how they thought the general topic of self-harm should be dealt with in elementary schools. We were interested in the feelings that encountering self-harm may trigger in staff and whether they believed they were lacking something to be able to optimally manage these incidents.

Our aim was to report the recurring themes as well as the contrasts between the respondents. Idiosyncratic statements were weeded out, so the result section aims to present shared understandings and repeated ideas that run through the interviews. The findings will be presented as three themes identified through thematic analysis. We named these as follows: 1. Participants' understandings of self-harm, 2. Social learning of self-harm and 3. A call for more knowledge. Each theme will be presented individually with comments and a complementary discussion, and the survey data will be intertwined to promote the ease of comparison. We will, however, remind the reader that there is a degree of interplay between the themes.

3.1 Participants' understandings of self-harm

This section starts by presenting participants' thoughts about prevalence of self-harm in elementary schools and continues by describing what behaviors respondents associated with self-harm, as well as functions and triggers participants ascribed to self-harm. This is succeeded by discussions of how the perception of motives and degree of seriousness can influence attitudes and helping behavior in staff. The section ends with a presentation of how school staff became aware that children self-harmed.

3.1.1 Self-harm in elementary schools

We were unsure what to expect when we set out to recruit participants for this study, as we assumed self-harm in elementary schools to be rare, and that staff may not label various destructive behaviors as self-harm in this age group. Several of the principals had knowledge

of children who self-harmed, although their experience was limited to a single or a few cases. Approximately half of the schools we visited said they had no experience at all with the phenomenon. A few principals eager to assist suggested we should visit the junior high schools instead where they knew self-harm to be more prevalent, while others expressed uncertainty whether they had encountered the problem or not. It may be that "elementary school children who self-harm" would only bring forth stereotypical associations of children who cut their arms and that we did not succeed in engaging the principals in exploring the subject in a broader sense. One principal believed however that all elementary schools to varying degrees experience children who self-harm. This contrasts with other schools where we were met with quizzical curiosity and bemusement when we presented the subject. This may be due to different understandings of what self-harm is, mirroring the disagreement in the literature, as well as lack of knowledge which could arguably lead to cases going unnoticed. Interestingly, the notion that self-harm is a rare occurrence in elementary schools was often coupled with the uncertainty of whether they were able to discover it, as exemplified by these two participants:

P1: I think it's uncommon in the elementary school at least.
P2: Yeah, I think so as well. It's probably a thing that we… we've experienced it and we've heard pupils talking about it, but we think that it's a rare occurrence compared to what we… yeah, it's possible that we aren't picking it up. We don't know that. (3)

We know from the literature that self-harm is frequently kept hidden by the child, so invisibility may be a valid concern. Parent reports usually deviate significantly from the children's self-report regarding their engagement in self-harm. Meltzer et al. (2001) found that among 4,249 11-15 year olds, 248 children reported harming themselves, while 78 parents reported that their child had tried to harm themselves. There was an agreement in only 38 of the cases, which speaks of the challenges staff face in trying to uncover self-harm. In addition to some incidents likely going unnoticed, some participants expressed that children at risk of later engagement in self-harm could be a target for intervention at elementary schools:

And there are perhaps more than we manage to discover. That is possible. Because, yeah, it's ok that it flourishes during middle school, but I believe it did not start there! There is something there that exists from earlier. Guaranteed. (7)

I think that the elementary schools don't have that many self-harmers, but we have several who eventually will become self-harmers. So we have to try and catch them before they do, and the elementary schools have an opportunity of doing that. And I think that we

didn't hear of elementary schools and self-harm before, but that we sometimes hear about it now, and that it occurs at younger age. (9)

We interpret these quotations to mean that there may be potential warning signs present at an early age which can alert staff to the behavior, and that knowledge of these could help staff prevent such behavior at an earlier age. Some of the interviewees expressed uncertainty about what to look out for, and some said they wished to learn more about the early warning signs of self-harm.

In the comments field of the online survey, participants were free to write whatever came to mind. Of the 63 respondents, 22 left a comment. 11 of these either said that they had not seen children self-harm, or that they perceived this to be more prevalent and relevant for adolescents. Six said they saw self-harm among children as a relevant and important area in which to do research. Seven wrote it is an important area of focus, and five said they wanted more information or hoped for this research to result in tangible suggestions to schools.

Although we acknowledge that self-harm is more common among older children, we argue that the low incidence may be affected by other variables as well. We believe that increased knowledge leads to greater awareness, visibility and detection, and that the different statements made by the principals cannot be accounted for by a true difference in prevalence. All of the schools were in close proximity to each other, belonging to five neighboring municipalities. It is interesting to note that one of the schools that denied having experienced self-harm was a school that did not have a school counselor position.

3.1.2 What behaviors are seen as self-harm

All of the interviewed staff had some experience with children who had self-harmed, although they were unsure at times whether "self-harm" was the appropriate label. Interviewees were asked to tell about a particular self-harm incident in detail and what behaviors they had seen the child engage in. They were encouraged to share their own understanding of self-harm, as well as what functions they believed self-harm might serve for children. This is of interest to better understand the diversity of acts children can engage in, what is regarded as an act of self-harm and how staff perceive children's motivation for engaging in self-harm behaviors.

Behaviors known by interviewed staff to have been carried out by children are listed in Table 1. A few of these behaviors were seen in children older than 13, and are marked as such.

Table 1: Self-harm behaviors known by staff to have been carried out by children

Harming the head:	• Banging the head in a glass door, desk, wall or floor.
Harming the skin:	• Stabbing the hand with pencils and compass tool. • Cutting the skin on the wrists, thighs, legs and arms. • Cutting or scraping the skin with scissors, paperclips, finger nails, pieces of glass, stones or soda bottle caps. • Picking on the skin to the point of bleeding. • Picking or gouging on wounds so they do not heal.
Harming other body parts:	• Pulling the hair. • Hitting oneself. • Pinching oneself on the arms and legs. • Slamming the hands in the desk. • Breaking the arm intentionally (older child)
Other apparently related behavior:	• Ripping clothes • Punching and kicking a brick wall. • Refusing to eat. • Holding ones breath to induce fainting (older child) • Jumping into icy-cold water. • Exaggerated clumsiness. • Pretending having a stomach ache when one does not. • Creating and being drawn to dangerous situations. • Intentionally falling down stairs.

Participants expressed difficulty defining what is and what is not self-harm:

No, that's how I believe my definition of self-harm is, grazing the skin (…) And then, if I think of the younger grades, in frustration and anger – if there have been any episodes –we have had pupils that have hit something, you know, or kicked something, things like that. But I haven't thought of that as self-harm, I have thought of that as anger and frustration. (5)

When I think 'self-harm', I think about that [cuts along the arm]. But that's perhaps totally wrong. (…) I think it's sort of a media thing, I mean if you, if I was told to define self-harm then I believe I could define it very broadly. It's probably a media definition that I have in my head. (11)

Cutting the skin was known by staff to have been carried out by children in 11 of the 12 interviews. As exemplified by the above quotations, cutting appeared to be the type of behavior the majority of staff associated with self-harm which will affect the kinds of incidents reported to us as self-harm. A few said they believed it was cutting we would be interested in hearing about, as the interview topic presented to them was that of self-harm:

But I believe head banging and what we can see there, what I… I call it self-harming, but I partly believe that I thought that you may be interested in cutting… but it is obvious we aren't putting that into the context as much as we should. It's not a lot of them either, but… I know a few examples, right, that we have – poking oneself, banging… (9)

The understanding that cutting is the behavior usually equated with self-harm, may result in other behaviors which are not automatically seen as self-harm being overlooked. Cutting is often highly visible and dramatic behavior which would promptly make the child in question a target for concern amongst staff. Other self-harm behaviors may not leave marks or be as visible, which may lessen the chance of the behavior being noticed, or it may be interpreted as something else than a child experiencing emotional distress. The frequency of self-harm also seemed to be affecting participants' judgments:

I think that it is something you do repeatedly, over a certain time, in a way; there is a pattern you have gotten into when something is difficult. (3)

There was a tendency for self-harm to be labeled as such only if the behavior happened repeatedly instead of being a one-time occurrence.

Second to cutting, banging the head against a surface and having some form of eating disorder or engaging in excessive dieting was reported most frequently by staff. In eight of the 12 interviews, staff reported to have seen pupils banging their head either against a wall, desk, the floor or a door. There was however an expressed uncertainty whether these behaviors should be classified as self-harm:

I never… when they are younger you can see that they are banging their heads in their desks and stuff like that yeah. I haven't even thought of that as self-harm. I got to say that. (3)

And often it is… banging the head, that's something we can see in even younger… not sixth and seventh graders, we don't see that as clearly, but we can sort of see a third and fourth grader doing it. Those who are in sixth or seventh grade now would perhaps not do it very… They would lock themselves in the toilets or something. But we can see such frustration in the younger. And we sort of don't know what… what happens to them in the future? (9)

The reasons for some participants experiencing difficulty labeling head banging as self-harm might be connected to the situations where the behavior was provoked. Head banging was often instigated by agitation or frustration, which may not automatically fit with the understanding many participants had of the reasons for self-harming, which is described in more detail later. Head banging was more frequently seen in the younger children, many of whom had a delay or deficit in language, communication and social skills. This is in line with Barrocas et al. (2012) who found that younger children – in this case children in the third to sixth grades (8-12 year olds) – were more likely to hit themselves than to display the more stereotypical cutting behavior, which is more often engaged in by older children – from ninth grade and upwards (14 years +).

In the latter quotation, participant 9 was concerned about what may happen in the future to the younger children who bang their heads. There is a possibility that young children who are prone to bang their heads or hit themselves as youngsters are at risk for engaging in other types of self-harm behavior later in life as they are already displaying maladaptive forms of dealing with emotional stress and frustration. Adults should take these developmental trends into account, and be mindful of the findings that younger children who experience distress will often engage in different forms of self-harm behaviors than older children. A child who punches the wall in anger may warrant a discussion with the child's parents and a conversation with the child to promote better understanding of what provokes the behavior. We argue that these children should receive early attention so that they can learn more adaptive coping skills. This way we can stop self-harm behaviors before they turn into a habitual response to stress which can be difficult to turn around later in life.

Only one pair of interviewees had a very broad understanding of how self-harm might manifest. They included not only direct harm done to one's body, but also mentioned pretending to be hurt when one is not (to avoid spending time outside in the school yard), creating and getting into potentially harmful situations as well as intentionally falling and being overly clumsy, all of which they had seen troubled children at their school engage in:

> *I would say that it is a form of self-harm when you seek out a situation that you know is really dangerous, but seek it out anyway, you do it with the risk of harming yourself badly, or that you will get hurt if you roll down the stairs. (12)*

These two staff members had extensive experience with elementary school children who self-harmed, and children as young as seven years old expressing suicidal ideations. They said that

they were not surprised when they learned of our choice of subject, and they deemed it very relevant to their daily work where they estimated having two to three cases a year, even more if they included children harming themselves during playtime. This school had invested a lot of resources in school counselor positions. Having a broad conception of actions that may constitute self-harm can make these behaviors more visible, with the consequence that more behaviors are picked up and considered as possible signs of distress (Simm et al., 2008).

The understanding of self-harm behaviors: Survey results

We asked survey respondents to write down what behaviors they associate with "self-harm behaviors". Table 2 lists their responses, regardless of having personal encounters with children who self-harm. Respondents were free to type their own replies in a text box, and most responses consisted of more than one type of self-harm behavior. Respondents were also asked whether they had observed or had experience with a young child (6-13 years) engaging in behaviors they would label as self-harm. Of the 63 respondents, 33 answered that they had done so, and their replies are found under "observed" in Table 2.

There were more reported incidents of children harming the skin and slamming the head or other body parts into objects compared to any other behavior. This corresponds with what we found in the interviews. Whether the understanding of what counts as self-harm affects what behavior is noticed, or if these findings truly represent the methods most utilized by children remains unknown.

We do not offer a full list of self-harm behaviors to provide a blueprint for what forms children's distress can potentially take. Instead, we wish to iterate the importance of looking into more than cutting behavior and we urge the investigation of the child's own experience of what caused them to self-harm.

Table 2: What survey respondents associated with "self-harm behaviors" and what self-harm behaviors they had seen children engage in

BEHAVIOR	NUMBER OF RESPONDENTS	
	Associated	**Observed**
• Harming the skin (with knives, razors, scissors, needles, compass, pencils, staplers), cutting, pinching, picking on wounds, grazing, stabbing, scraping, scratching or gouging the skin	54	22
• Slamming or banging the body or body parts (including the head) into objects	20	13
• Hitting oneself	12	5
• Burning the skin	10	1
• Refusing to eat, eating too much, or eating inedible substances (paper, pencils, rubbers)	9	3
• Biting oneself	6	5
• Pulling out hairs	5	5
• Pills, overdosing, getting high	5	0
• Putting oneself in dangerous situations or isolating oneself from others	5	2
• Jumping from heights	4	0
• Other	5	1

3.1.3 Functions and triggers participants ascribed to self-harm

Interview participants reported a variety of functions they thought self-harm could serve for children, as well as many different triggers/causes of such actions; see Table 3 for a full summary. Many regarded self-harm as a way of transferring psychological pain into a physical pain:

They have a life-situation, and thoughts around their own existence that are difficult for them to manage. And they hurt themselves. That is… that is the classical form of removing the day. You remove the pain right now. (2)

When it became too painful on the inside so that you then get… she focused on that, it removes the thoughts that are… because then you focus on the pain in the arm. Right, it's that simple really, it becomes a strategy of sorts. (5)

The participants believed that self-harm provided a way of transferring unbearable psychological pain onto the body, which would be easier to handle, or that it could serve as a distraction from emotional distress. This understanding resonates with the idea of self-harm being an emotion regulation strategy. Several participants also said that self-harm is a cry for help, a means to be seen or for children to express that they are not alright:

It was probably little time for things at home. Her sister took up a lot of space. So it was probably… we boiled it down to that it was a way of saying 'hello, here I am'. (6)

The first I envision is frustrated youth, who are not being seen, or haven't been seen. And that you… that it's quite a desperate cry for help that you are not ok. (12)

In the above quotations, the participants seem to express that self-harm is a means for children to communicate to those around them that they are in need of support. The self-harm becomes a tool for children to convey that they have a need to be seen. According to Walsh (2007), one reason for people self-harming within a group is because they think that verbal communication is not powerful enough to convey the intensity of their anger, sadness, anxiety or depression, an understanding one participant also seemed to express:

It is… sort of a way to show that 'I am frustrated and tired and…' Maybe it is even worse when you cannot communicate that through language. (4)

Self-harm is here perceived as a way to communicate frustration and tiredness better than the frustrated and tired child could have done through the use of spoken language. Some of the interviewees also seemed to have this understanding of self-harm; that the pain inflicted onto the body shows a child in severe distress and strongly communicates a need for help:

You feel perhaps that it is an even greater need to… you do that either way but, that you go into a state of alarm, that 'woah this is serious; here we need all the help you can get'. (5)

We've had children who can bang their hands, smash things, they can… There are several ways of getting frustration and aggression out, but I think at least, those who move on to cutting themselves, harming oneself, then that pain becomes larger sort of, there is a limit there that… (…) But when the physical pain has to become so big, or the size of the physical pain then, tells a bit more of what's inside… how much they're hurting really. (9)

We interpret these quotations to show that staff members judged the child to be in greater distress once they engaged in self-harm. Interviewee 9 also seems to relate the size of the physical pain to the size of the psychological pain. Some children may believe that for others to understand their plight, they must communicate it in a dramatic and visible way to be taken seriously. The self-harm as communication of distress may be seen as more powerful than telling adults through verbal language.

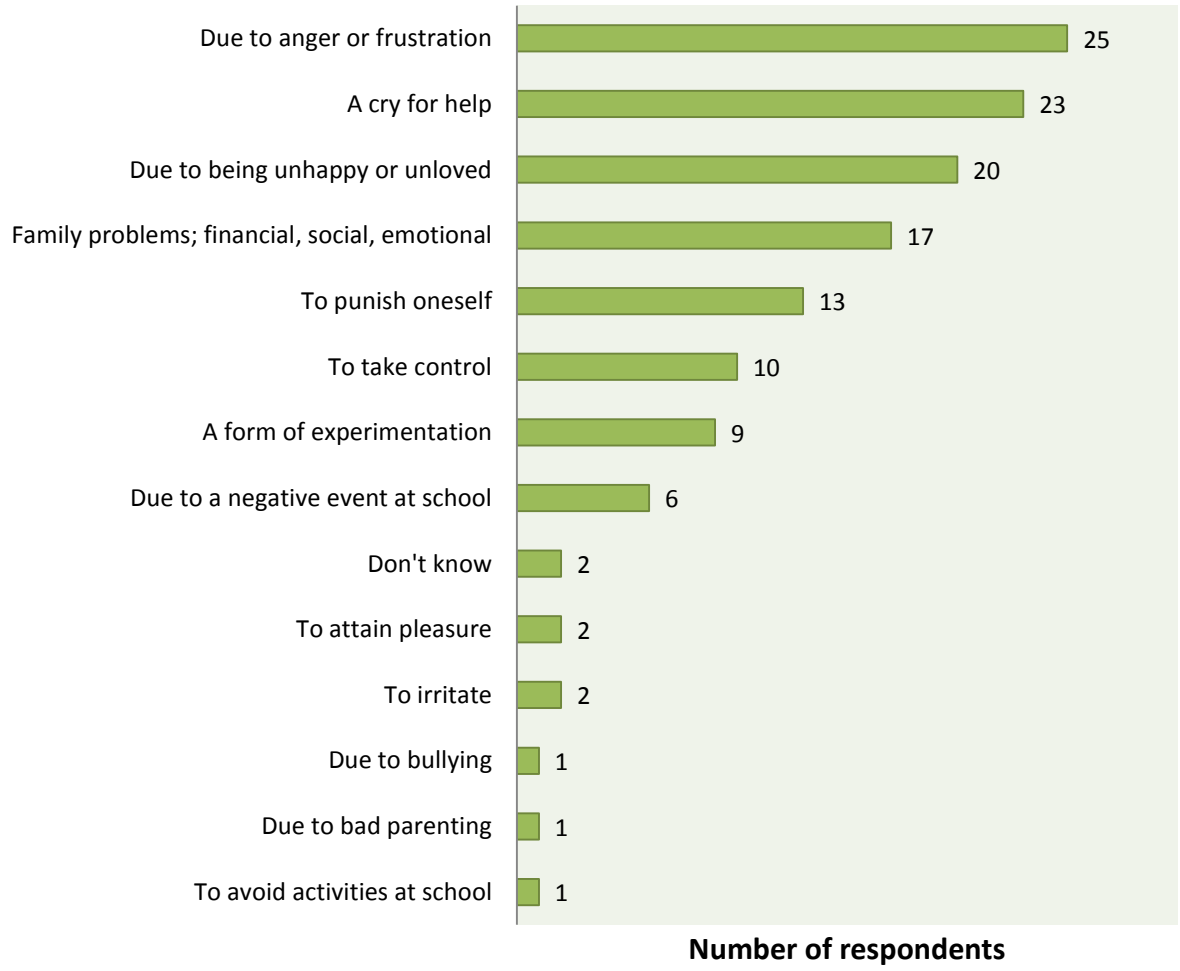
Table 3: Functions staff believed self-harm could serve, as well as causes and triggers

Intrapersonal acts:	• Feeling angry, frustrated, upset, aggressive or anxious • A way of coping with inner pain by transferring it to the body; a shift in focus, removing the inner pain, transferring the problem to somewhere else, acting inwards instead of outwards, easier to handle physical pain than psychological pain • A form of experimentation • Punishing oneself; being angry at oneself • Doing it for fun • To take control over one's inner pain • A distraction from daily life • Curiousness
Interpersonal acts:	• To communicate; either a cry for help or a need to be seen, showing that you are out of control • Peer pressure • Copying a friend/sibling who self-harms • For attention • To stop parents from divorcing • Showing off • Trendy in certain subcultures • To punish one's parents
Causes or triggers:	• Family problems; child not getting enough attention at home, child feeling "invisible", unstable family relations, divorce; the child not knowing where he/she belongs when parents divorce • Poor parenting; parents spending too little quality time with their children, "curling parents"; parents catering too much to their children's needs making them unable to cope with the demands of life later on. Attachment problems • Child having a natural vulnerability • Life becoming too overwhelming; feeling unable to master the demands put on them • Due to trauma; unresolved emotions • Conflicts at school; comments or perceived criticism from peers or teachers, troubles fitting in, not being able to master the curriculum • Being unsure about one's identity; the transition from childhood to adulthood; feeling different.

The functions of self-harm: Survey results

Survey participants were asked to share their understanding of why they thought a particular child they had experience with self-harmed. Their replies are found in Figure 3. The majority of respondents had an understanding of the child in question experiencing anger or frustration, and that the self-harm served as a means to get help. A few respondents saw it as a form of experimentation or a way to irritate others.

Figure 3: Why survey respondents thought a particular child engaged in self-harm



When asked what participants thought might be the reason for why some children self-harm, regardless of whether they had witnessed a child engaging in these behaviors, they were free to write their own ideas. Their replies can be found in Table 4.

Table 4: What survey participants believed to be the reason why some children self-harm

BEHAVIOR	Intra-personal	Inter-personal	Causes/ Triggers
Feeling angry, hopeless, frustrated, anxious, depressed, unloved, stressed, nervous	29		
Emotion regulation; a way of coping with inner feelings, unable to handle their own feelings in any other way, a shift in focus, transferring inner pain to physical pain	16		
To punish oneself	8		
A form of experimentation	7		
To take or regain control	7		
To attain pleasure	3		
Being bored	1		
To communicate, either a cry for help or a need to be seen when they feel misunderstood or neglected, showing adults they are not ok, to get attention		30	
Peer pressure or copying another		4	
Family problems; social, emotional, financial, parents abusing substances, poor parenting			19
Poor self-esteem, poor self-image, feeling unsuccessful or of less worth			13
Psychological disorders or emotional disturbances			10
Bullying or social rejection			6
Abuse: emotional, physical or sexual			5
Lack of words or poor communication skills			4
Social problems			4
Total	**71**	**34**	**61**

Most respondents had an understanding of self-harm being the result of internal distress experienced by the child, but several replied that it was a means for children to communicate to adults that they were not ok and that they were in need of help. Their responses also give an indication of what adults think of the causes of self-harm among children. Most saw family problems as the most likely cause. Secondly, poor self-esteem and psychological disorders were reported. Bullying, abuse, poor communication skills and social problems were reported less frequently.

There is, to our knowledge, no research where young children have been asked about their motivations for self-harm, and we cannot be sure that the teachers' understandings of the functions or motivations behind these acts are the same as what the children themselves are experiencing.

3.1.4 But is it serious? The relationship between attributions and offering help

Staff we interviewed had a tendency to dichotomize between serious and less serious acts of self-harm. Incidents of children cutting their skin so deep that blood was drawn were always interpreted as serious. Inferences made about the child's motive to self-harm also affected how staff labeled the severity. In the following section we investigate whether these subjective inferences can affect staff willingness to help the child. The following quotations exemplify judgments regarding severity:

P2: One of them was real, and the other was also… I mean, we took it really seriously. But one of them has a lot of trouble with himself and his home situation, and the other that only was testing it out a bit.

P1: Only sympathy…

P2: Only wanted to test to see if it would leave any marks and… (4)

P: No, I've seen both girls and boys who've scraped the skin a bit on the underarm with something, and then I say 'what's that then,' 'no, we were just kidding around a bit'. Yes, and then you take it for what they say then until the opposite… until you start to think the opposite so to speak.

I: You've seen both serious scraping and more…

P: Yeah, yeah! Sort of like unserious, sort of, that happens all the time that children play with knives or other things. (8)

While one of the participants of interview 4 states that a boy they knew to have self-harmed did this to show sympathy to another child, the other participant attributed this to a non-serious form of "testing out" the behavior. Interviewee 8 more generally attributes some types of self-harm to playing around. Even participants who, in line with current research, believed self-harm to serve an emotion regulation function, did at times classify certain incidents of self-harm as less serious than others. Most participants were explicit that they always took incidents of this kind seriously and talked to the child to find out what lies beneath, and we experienced that all, except for a few, made these dichotomous judgments after hearing the child out. It is however important that adults validate their hypothesis of the reasons for a child's self-harm with the child and do not jump to conclusions about whether the self-harm is the result of "true" distress or provoked by boredom.

The attribution that some children self-harm for experimentation purposes, or that they are merely doing it because a friend is doing it may influence the responses they elicit from staff. Knowles, Townsend and Anderson (2012) interviewed community youth justice staff in England exploring how they managed young offenders who self-harmed. They found that socially motivated or interpersonal self-harm was dismissed as "just" attention seeking or manipulating by the staff, and these youths were portrayed to be less at risk and not representing genuine distress. On the other hand, youths about whom they were genuinely concerned, were assumed to have motivations that were deemed to be psychologically, as opposed to socially, underpinned.

Young people themselves however, do not report this dichotomy between "real" distress and instrumental self-harm. Through the use of self-report data, Ousch, Noll and Putnam (1999) discovered six factors explaining the motivations behind 75 adult inpatients' self-harm. In order, the following factors were found: 1) affect modulation, 2) desolation (desire to escape feelings of isolation or emptiness), 3) self-punishment and other motivations, 4) influencing others, 5) magical control of others, and 6) self-stimulation. 1, 2, 3 and 6 involve intrapersonal dimensions, that is, acts that affect the persons themselves, whereas 4 and 5 are related to interpersonal dimensions, namely acts that aim at influencing or affecting other people. Thus, the study by Ousch and colleagues (1999) found that interpersonal factors appeared less important compared to intrapersonal factors. This finding was supported by Rodham, Hawton and Evans (2004) who found that English 15 and 16 year olds endorsed interpersonal motivation like "frightening someone, getting attention, and getting their own back on

someone" (p.82) less frequently compared to intrapersonal motivations like "relief from a terrible state of mind, to die, to punish themselves, and to show how desperate they were feeling" (p. 82). In a similar vein, Nock and Prinstein (2004) studied a sample of 89 adolescent psychiatric inpatients who reported at least one incident of self-harm the previous 12 months. They found that items related to the automatic-reinforcement functions were endorsed much more frequently than items related to social-reinforcement functions. More than half of the patients who self-harmed (52.9 %) reported engaging in self-harm with the intention to relieve bad feelings. The automatic-reinforcement subscales were endorsed by 24-53% of these patients, compared to the social-reinforcement subscales that were endorsed by only 6-24%.

This lends support to the notion that for a large group of individuals, self-harm is a means of reducing internal distress as opposed to an attempt at influencing the behavior of others, and even where interpersonal reasons are reported, it may not be equated with an absence of distress. Some of the participants of the current study who displayed this dichotomy said however that they did not dare to make a decision on their own whether the self-harm presented was genuine or not, so they referred the child to external health services to make sure they were not making an error. It is commendable that so many of the interviewees chose to speak directly with the child and not jump to conclusions, but this finding may be colored by the sample that mainly consisted of school counselors, who are expected to take on that role. One school counselor said we may have found more reluctance among class teachers:

But like I said, I think you'd be surprised about the teachers, teachers who would feel this is terribly difficult and… perhaps not disgusting, but at least a bit… something they do not want to… and that they don't know a lot about either (9)

This participant paints a picture of a qualitative difference between school counselors and class teachers, stating that many class teachers would find the topic of self-harm so difficult that they would hesitate to address the problem. She mentioned that teachers should not be left on their own with these children, and that they should use the school counselors or school nurses available when they discover these children. A teacher told us the following:

I think she liked that school was a safe-haven, but I also think that it was difficult being at school. (…) Because she was a bit afraid that I would talk to her all the time. We talked quite a bit, we had conversations every now and then, but we did not talk about [the self-harm]… we talked about how she had it at school. (10)

This teacher seems to communicate that he found it difficult to talk to the child about the self-harm. He also told that he had been given the advice not to talk about it by the youth psychiatric service. The topic was avoided with the assumption that school was to be a safe-haven where difficult things were allowed to rest and that external health systems were dealing with the self-harm problem so that the school did not have to. We agree that there may be decisions to be made regarding the best time and place to talk to about self-harm, but we suggest that it should be the child that makes these calls, and that the topic is not intentionally avoided because adults find it too difficult to talk about. In this example, the child was cared for in other ways, however. It is very understandable that helpers feel unsure about how to best approach these children; hence, teachers must be empowered through more knowledge and be given supervision on how to talk to these children to both increase their own feelings of efficacy and to offer children an opportunity to talk if they so desire.

3.1.5 Understanding functions can be informative for interventions

Understanding possible functions and the triggers that provoke self-harm can stop the behavior in its tracks. For example, if a child is known to self-harm after being disciplined by a teacher or falling out with others during playtime, these incidents can be targeted to practice alternative reactions as opposed to proceeding with the usual pattern of self-harm. Offering the child a place to come and talk as an alternative measure can be helpful, which was practiced by some of the participants interviewed:

Because when we have been direct with the children, and said that 'can't you come here directly' sort of, they have done that. Right, so the injuries during playtime stopped, because they came here instead. (12)

In this instance, children hurting themselves during playtime had declined after staff had approached them directly and encouraged them to come and talk when the urge to self-harm arose.

One teacher who had a pupil who was known to bang his head when frustrated, worked on alternative reaction patterns when emotions got out of hand:

And you could make them aware that when you did it the way we agreed upon, they did not get into conflicts, and then it did not result in the head in the wall or pencils in the palm of the hand. Because you dealt with it preemptively. So really become a slave to the

routine. (…). So on the occasions where you had the possibility of finding out what triggers unwanted behavior, you could try and figure out what could be done to stop it in its tracks. (1)

Some teachers also attempted to encourage children to put their feelings into words, which can be a good intervention to prevent acting out either through aggression or self-harm:

We work a lot with boys that must put their feelings into words; 'man, you need to speak! Instead of standing there like that, say why you are pissed off!' It is perfectly fine being pissed off, but you got to say it. Right? Put your feelings into words instead. And we are here to listen to them. Right? So it is hard to understand when you stand there banging your head into a wall. Can't understand why you are angry, you got to talk. (4)

Then I discovered that he was scraping on a wound that started to bleed. And I asked him directly; 'do you harm yourself because you hurt inside? Is there something on your mind?' And then he broke down completely and started crying and told me quite a lot. (…) So yesterday I removed all the things close to him, and then he broke down and managed to talk about what he… he was very nervous about a presentation. (12)

The above quotations illustrate that staff had some ideas of what might work to prevent the self-harm from occurring, and that they had experienced a decline in self-harm as a result of their actions. These serve as examples of what types of basic interventions can be done by staff who know the pupil well enough to be aware of what triggers the child to self-harm.

If self-harm is understood as a rational act for regulating feelings, rather than a means for irritation or manipulating others, staff may not be as afraid of rewarding or strengthening the behavior by showing the child that they care. Banning the behavior or reproaching the child will likely be counter-productive and be experienced as invalidating. We suggest that children who are discovered to self-harm are approached by teachers and other caretakers with respectful and nonjudgmental curiosity. This will show the child that one is genuinely interested in learning more about the child's self-injury and that one strives to understand the processes behind the behavior, rather than wanting it to go away quickly or dismissing it as attention-seeking behavior. Approaching the child with the question "what does cutting do for you?" will open the door for empathic understanding of the antecedents and will provide clues to the degree of distress experienced by the child and what preventions can be applied. This approach is in line with the common factor theory of therapeutic change, where empathic understanding, positive regard and congruence have been found to be of importance in establishing a good working alliance and promoting positive change (Lambert & Barley, 2001; Patterson, 1984).

If the functions behind the child's self-harm behavior appear to be emotion regulation, Walsh (2007) suggested intervention to be targeted on (a) reducing emotional triggers, and (b) teaching alternative emotion regulation skills. However, if the function behind the child's self-harm seem to be interpersonal in nature, it may be better to focus on social skills training and better communication skills.

A study based on 2,273 responses from the Norwegian dataset of the CASE project, investigated what youths themselves said about approaches to self-harm prevention, their experiences with the help system, and what can be done in schools and neighborhoods to improve the life of young people (Sandlie & Ystgaard, 2007). They found that youths felt they had too little information about the various help systems; namely where to go and what help they could receive. The youths also stressed the importance of being met with respectful attitudes and the importance of being taken seriously. They wanted adults to talk to them and not only about them. They wished for a health service to be available at schools, where they could get help exceeding ordinary working hours, and many desired psychological welfare to be made part of the school curriculum. Importantly, several teenagers said they would be reluctant to seek help due to psychological distress because they found it embarrassing and that it costs money. We argue that the school is an excellent arena to break down these barriers by spreading knowledge of psychological wellbeing, which can promote a shift in attitudes and reduction of stigma. Schools can also inform the students that there are free help services available, including the school counselor service and school nurses.

3.1.6 How the staff became aware of the child who self-harmed

As noted earlier, some staff members suspected they are not able to discover all children who self-harm; a valid concern as we know from the literature that self-harm is often kept hidden from adults. These two participants illustrate the uncertainty most interviewed staff had about their abilities to discover children who self-harm:

I think that I am afraid that we are not discovering everything. That was the first I thought about. I don't think I've worked a lot with that problem, and then I think it's probably more that we do not discover. And I don't think it concerns only this subject [self-harm], but mental health in general. (6)

Yeah, she never… she never sort of showed it by uncovering her arms. She wore long sleeves pretty much. (10)

Reasons making discovery difficult mentioned throughout the interviews included that teachers had too many pupils to attend to in class, making the individual pupil almost invisible, and that the child who self-harms would actively try to hide this from staff by wearing long sleeves or otherwise covering the wounds. Some also expressed uncertainty about the warning signs of self-harm, and wished to know more about what signs to look for.

We discovered that it was often the child who self-harmed who approached the school counselors to disclose it, or that they had friends who notified staff out of concern:

She came together with a classmate who… These two spend a lot of time together, and share many thoughts. They started at the same time, and they came and… they were very afraid, but they absolutely wanted to tell me and to show me. (2)

They've come with friends yeah, and then they have talked to us about it. It has been… it's been difficult, they have maybe been here several times, and in the end they said it. (3)

Children and youth share secrets with peers to strengthen their bonds and to get support. Sometimes adults are kept in the dark due to an expected clause of silence or a deeply felt loyalty towards the friend who shared the secret (Sandlie & Ystgaard, 2007). Some of the participants said that they had been notified by friends of the person self-harming due to feeling distress of their own and not knowing how to handle the situation. Lowering the bar for notifying adults can be done through an explicit differentiation between what is being gossip and what is caring, similar to what is done in the bullying prevention program Olweus (http://www.violencepreventionworks.org):

No, we came to know, you understand that when you're a school counselor, then it takes a few seconds and then we have, we know everything. If it's through Facebook or wherever, we will know most of it really. Not because someone is gossiping, but because they know that, that you… yeah, care about each other. Friends that care. (4)

This differentiation between gossip and caring could easily be extended to target not only bullying, but also self-harm, to increase the chances of friends and peers notifying adults when observing such behaviors.

The trend in the current data material which points to children disclosing to staff about their self-harm, or that their friends notify staff in their stead, is supported by an American survey of 443 school counselors from high schools, junior high and elementary schools (Roberts-Dobie & Donatelle, 2007). 81% of the counselors said they had worked with a child or adolescent who self-harmed at some point in their career. When asked how they became

aware of cases of self-injury, 67% said they were informed by a fellow student, 65% were informed by a teacher or coach, 51% were informed by the child or adolescent him/herself, 48% of the counselors recognized the behavior themselves, 26% were notified by the school nurse, and lastly, 18% were informed by the student's parent. Signs to look out for can be direct, such as marks and scratches on the child's body, or indirect signs of emotional problems such as mood changes, acting out, changes in eating habits and troubles sleeping.

This points to the importance of both staff and peers being to some degree knowledgeable and informed about self-harm as they are the primary source for identification of self-harm among youth. Staff should be encouraged to explore the issue with young children, so that they can be identified early and receive help. This is easier done if the school counselors have a visible role at the school and are making an effort to promote their services. A secure room with distractions such as teddy bears, games, colored pencils and the like can make it easier for a child to share difficult experiences so that they are not forced into a face-to-face conversation with an adult, which can be threatening and limit self-disclosure. Several of those we interviewed utilized these methods. One pair similarly had positive experience with taking children for car trips, which puts less pressure on the situation, allowing the child's gaze to wander as they talk instead of facing an adult directly.

3.2 Social learning of self-harm

During the recruitment process a principal expressed his concern that the more we talk about self-harm, the more prevalent it will likely become. He expressed genuine care for children's emotional wellbeing, while displaying insecurity regarding the best way to approach the subject of self-harm. This did not however prevent him from referring us to the school counselors to participate in the study. We will take a closer look at this principal's concerns, as there are reasons to suspect that the incidence of self-harm has increased in recent years (Nock, 2010). This section presents the participants' views on social learning effects of self-harm, and their opinions on whether more information could lead to an increase in such behaviors among young children. This is supplemented by a discussion of whether self-harm should be a topic of discussion with children or not, drawing on both the possible pros and cons of doing so.

The word “contagion” was often used throughout the interviews instead of “social learning” when the possibility of self-harm spreading amongst children was discussed. Contagion is thus used as such in following quotations, although we want to emphasize that the semantic meaning reflects the psychological form of contagion (Farlex, n.d.) and is used interchangeably with social learning.

3.2.1 Social learning effects

Several of the respondents reported having observed what they interpreted to be social learning effects of self-harm.

Yes, a close friend. She as well started cutting herself a bit, sort of like a contagious effect. (10)

Yeah, together here at school. One of them had probably done it at home, and the others were sort of ‘cool, let us see’ right? And then they had followed suit. (4)

P2: But she looks up to a friend two grades above her who is doing the same thing.
I: Who self-harms?
P 2: Mhm. (…) So… Sees that she gets a lot of attention, right. (4)

These participants appear to communicate that self-harm may spread as a form of experimentation with dangerous and thrilling behaviors, or that peers can engage in similar behavior to attain a sense of cohesion and to attract attention from adults. Studies done in institutions have shown incidents of self-harm to cluster in time (Rosen & Walsh, 1989; Taiminen et al., 1998; Walsh & Rosen, 1985) and others have found self-harm to be significantly associated with knowledge of self-harm by friends or family members (Alfonso & Kaur, 2012; De Leo & Heller, 2004; Hawton et al., 2002; Muehlenkamp et al., 2008; Nock & Prinstein, 2005; O’Connor et al., 2009). Local “epidemics” of particular types of self-harm have also been reported, including ingestion of yellow oleander seeds in northern Sri Lanka (Eddleston et al., 1999), urethral insertion of foreign bodies in a maximum-security hospital (Rada & James, 1982) and “choking games” in the form of self-strangulation by hanging from continuous cloth towels in Canadian schools to experience the sensation of impending loss of consciousness (Le & Macnab, 2001). Furthermore, findings by Krishnakumar and colleagues (2011) suggest that children can turn to self-harm after being influenced by real life models, newspapers or television programs.

Besides subjective observations, more general thoughts about the social learning of self-harm were also common. Some expressed that they were not afraid of social learning effects:

If you create an environment in a class where you can talk about things like that, without making a big thing out of it, where you can talk about things in a class, share experiences, so that they know what it is. When you know what something is, you know you shouldn't be doing it, perhaps. I mean, you learn you shouldn't hit someone, that doesn't necessarily result in more people hitting. (1)

We can have openness and talk about it, because either you're there or you're not in a way. (…) So I think like that in relation to self-harm – without really having given it thought before you confront me with it – that openness is not a factor promoting an increase. I believe people still will choose to distance themselves from it. But then they know more about it. (11)

In contrast to these two participants' lack of concern about social learning effects, many considered social learning of self-harm to be a phenomena frequently occurring in today's society:

Yeah, that's something I've been thinking, sort of a curiousness… without me knowing for sure, I just think that it could quickly become like that. I have to say that it's been a while since I was young, and I never heard of these things. But it has flourished in recent years. (3).

The participant states that she has been wondering whether self-harm has actually increased in later years due to social learning effects. Similar concerns are evident in the online survey, where 19% of the 63 respondents said they thought self-harm would increase if children were given more information on the topic, 35% said no, and 46% were unsure. This illustrates that there is an experienced uncertainty among school staff of what consequences increased openness of the topic may have for children. This was also found in a questionnaire-based study of 122 North American school counselors (37 of them employed in elementary schools), where 66% of the participants said they believed self-harm to be contagious (Kibler, 2009).

3.2.2 Self-harm as a topic of discussion with children

The interviewees and online survey respondents expressed different opinions regarding what consequences social learning should have for whether or not to talk openly about self-harm with children. One of the school counselors expressed the concern to be of such importance that it would justify total silence about the topic:

You have to keep in mind that children have a vivid imagination, and that they can try… that children can easily test out things you talk about. (…) You don't talk about it unless there is a need for it! And I think that in a group, if you discover that one is doing it, then I believe that it may not be wise to address it with the entire group. Because then you have five others that want to try it afterwards. So you rather work with the one person. (8)

The participant argues that he sees no need to talk about self-harm if there are no children in class presenting with this behavior, and that if he knew about a child who self-harmed, it would be talked about only with the affected child. The reluctance to talk to a larger group of children or their class seems to stem from the perceived danger of "putting ideas" into children's heads. Correspondingly, two respondents of the online survey used the comment field to say that they felt it was a bad idea to talk about self-harm, that it might give "some bad ideas" to children and that, rather than being talked about, it should be managed only if it appeared as a problem. In contrast, other interview participants were more positive to the idea of an open dialogue, although most were still expressing some concern about potential learning effects.

I believe it's two-edged, because you can talk… It's natural to talk to a pupil about self-harm when you know that, or think that she wants to talk about it. But to talk generally to everyone? Mm. That I think would be more difficult. Because I would think that, 'woah, perhaps some are getting ideas now'. (…) I participate in class meetings and the like, but I do not think I have heard this addressed as a subject. Perhaps it should be? (6)

P1: Because, young children that we have here quickly go 'oh, that sounds exciting, we have to try that', when they have never heard about it before. Like a contagion…
I: So if they get information, you think that there will be a contagion effect…
P1: Yeah, it at least has to be very correct that information, not simple like 'someone does this' (4)

As illustrated in the above quotations, a positive attitude about making self-harm a topic among children was followed by a simultaneous emphasis of the importance of a deliberate approach if this is to be done. Hawton, Saunders and O'Connor (2012) provide a list of factors considered "key challenges to prevention of self-harm and suicide in adolescents" (p. 2,379). The list is divided into aspects related to understanding, intervention and prevention of self-harm. It stresses the importance of understanding social learning effects and the influence media has on adolescent self-harm and suicide, while at the same time underlining the usefulness of decreasing stigmatization of suicide and self-harm. The authors believe this will have implications for how media should ideally present information about self-harm, and they emphasize both the possible dangers of pro-suicide websites and chat rooms, as well as the

potential preventive contributions of online support groups and traditional crisis helplines. Pro-self-harm websites are not mentioned in the article, but they are easily found online.

In accordance with Hawton et al. (2012), we acknowledge that openness about self-harm could have both positive and negative consequences, and that negative consequences can be minimized if we learn more about the mechanisms underlying self-harm. Following most of the interviewees' reasoning, we argue that instead of totally discarding self-harm as a topic to be discussed with children, we must focus on questions like how, by whom, where and when it is optimally done. Several arguments put forth by the interviewees about reasons why self-harm should in fact be talked about further support this notion. Regarding learning effects, one of the respondents reflected upon the related topic of "learning of taboo":

And that also applies when you talk about psychological health, how you handle defeats and difficult things and such. If you show that this is something you feel is difficult yourself, you can quickly transfer that to pupils. You mustn't underestimate that your attitudes can transfer to them. And if you are a person that can talk about everything, 'what are those marks on your hand', if you are that type, then the pupils will know that you're the type that when you see something, you talk about it, and that it's not necessarily dangerous to talk to the teacher about it. (1)

As suggested in this quotation, it may be argued that the consequences of adults being afraid of talking about something can be just as harmful as the possible pitfalls of actually talking about it. The implications of the systematic avoidance of the topic may signal to children that self-harm is shameful and should not be disclosed, which may be more harmful in the long run than deliberate openness and a willingness to talk about the issue. If a teacher strongly feels one must avoid talking about self-harm with the pupils, he or she may also come to express avoidance or rejection towards a child in class who self-harms, be it intentional or not. This conveys attitudes that can be picked up by other children, which in turn can negatively affect their behavior towards children who self-harm. One study found that classroom teachers' like or dislike of a child in their class affects peer acceptance (Chang et al., 2007), and it is reasonable to assume that a teacher's negative attitudes towards self-harming behavior could have similar effects.

This leads us to the potential positive effects that discussing self-harm with children may have. Possible effects mentioned by participants were:

- A probable increase in the number of children discovered through reporting by friends:

There would be more reports because the children in the class would become more aware, and perhaps dare to ask 'do you harm yourself', like 'do you scratch yourself on purpose' sort of. Because you know that you aren't supposed to in a way, and that it is a sign of not being well. (12)

- Greater knowledge and awareness:

Yeah, and I think that it's about enlightenment, to talk about it and make people aware of it. It's the same as with bullying. That's the same thing. (11)

- Promoting understanding and a supporting attitude towards children who self-harm among peers:

It may be important that those who are around also understand that it is a person who struggles and not someone who just wants attention or turned 'emo' or whatever. That it may enable them to get some support from those around them, instead of being rejected. (9)

I think it's important that other kids see this, that friends sort of can make a difference for the individual. (7)

- An opportunity for children who self-harm to experience that they are not alone:

You know that girls in the 14-15 year old range that struggle with eating disorders are on the Internet. Read 20 blogs a day about others who perhaps experience the same. While children aged 8 who harm themselves, they don't do that. They may think they are the only ones in the whole world doing those things. (12)

- Putting self-harm in perspective by suggesting alternative coping methods:

Yeah, it at least that information has to be correct, not simple like 'someone does this', but that it is… that you perhaps are struggling, and turn to different solutions that aren't as smart, and what you can do instead. (4)

With self-harm you can perhaps do the same. Inform that this is something people can do towards themselves, if you are not feeling very well and things like that. And that there are ways to get help. (12)

Summed up, the participants saw many potential benefits of introducing the topic of self-harm among children, including decreasing the taboo associated with self-harm, increasing the probability of peer discovery and reporting to adults, promoting greater knowledge and awareness about the issue, promoting understanding and a supporting attitude towards

children who self-harm, allowing children who self-harm to experience that they are not alone and the possibility of putting self-harm into perspective by suggesting alternative methods of coping.

A final point worth mentioning is the question of who will (or will not) be in danger of social learning effects. This was reflected upon by two of the interviewees:

And if you start to harm yourself because you have seen a movie and you perhaps recognize the painful thoughts or something, then it may be that you test it out. But that may be a sign that you need help. (12)

What happens is that children who struggle and are in distress, carry a burden, they hear about it and try it out, and then discover that it actually helped. In that way I think it's contagious.(9)

These respondents perceived those in danger of imitating self-harm to be children already at risk, who would be tempted to try this out as a method of coping when learning about it. As described earlier, studies indicate learning effects of self-harm are generalizable from the psychiatric unit setting to community. The community studies do not however report the characteristics of those imitating the behavior. The question of who will and will not do this is left unanswered and more research is needed to clarify the characteristics of those vulnerable to social learning effects. In line with the above quotations, however, we hypothesize that the relationship between social learning and more information may not be as simple as once you tell children about self-harm, they will all become affected by social learning effects. The respondents' arguments that already vulnerable children are most likely to imitate self-harm, speaks of the need for these children to learn alternative coping strategies and receive extra attention. Children will sooner or later learn about self-harm, whether through family, friends or the media. Vulnerable children will be in danger of social learning from somewhere else, if not from school. It could thus be of great importance that schools provide a safe arena for children to get to know this topic and suggest alternative paths to deal with distress.

Questions arise regarding the best ways to talk about self-harm with children. During the writing of this thesis we learned about a Norwegian dance performance depicting eating disorders and self-harm, that had been stopped by critics due to the main focus of the show (Johannessen, 2012). Rather than presenting alternative coping methods and focusing on the way out of self-harm, the show described several different methods of self-harm and suicide. A lowered daily calorie consumption and exaggerated exercise for a girl with eating disorders

was also depicted. Worries spurred by this show are related to what is suggested by the current study, namely that openness about self-harm could lead to social learning effects (M. I. S. Pettersen, personal communication, December 20, 2012). This might not imply total silence about the topic, but rather a careful consideration of what would be the most suitable approach (M. I. S. Pettersen, personal communication, December 20, 2012). Critics were worried about the effects of the detailed descriptions of methods and consequences in this show. Accordingly, one caution could be to avoid mentioning methods and possible consequences of different types of self-harm. Such procedures are at present supported through research evidence on suicide prevention (Crane, Hawton, Simkin & Coulter, 2005; Pirkis, Blood, Beautrais, Burgess & Skehan, 2006).

To minimize unsuccessful prevention endeavors, we encourage future studies to focus on the topic of social learning of self-harm, and on how best to talk about self-harm with children without provoking unbeneficial outcomes.

3.3 A call for more knowledge

The last theme will be interwoven through three interconnected sections describing aspects relating to the importance of more knowledge of self-harm among elementary school staff. The first part presents and discusses participants' thoughts about reasons why knowledge about self-harm is important. The second part constitutes participants' feelings of inadequacy in relation to children who self-harm. This is followed by a discussion of how these feelings relate to what they are doing already for these children, and of what the school as a system as well as individual staff members can contribute in terms of help to children who self-harm.

3.3.1 Why knowledge of self-harm is important

Interviewees regarded knowledge of self-harm among school personnel as important due to several reasons that will be presented in the following section. When reflecting on the different effects of knowledge, they referred to their own experiences, to subjective observations at their schools (or elsewhere), as well as more general thoughts. The strong emphasis school personnel place on this issue is also evident in the online survey, where 89% of the survey respondents said there was a need for more information about self-harm. Only

29% said that self-harm had been a topic of discussion among staff at their school, which illustrates that even though many think the topic should be talked about, this is often not done.

One of the interviewees described how her first encounter with self-harm had made her actively search for information about it:

P: (…) and learn more about it. Often when you encounter, - when I met that first case, the first thing I thought was 'woah, this is something I have to read more about', right.
I: What did you do then? Did you go and find books about self-harm?
P: Yes, or I googled and stuff… Mmh. (5)

The interviewee expresses having felt a strong, personal need for more information which she consequently acted upon. We interpret her words to imply that information was something that could make her feel more secure in dealing with this child. Another interviewee had attended a class about suicide prevention and said that the added knowledge enabled her to feel more confident when engaging in conversations about the topic:

But that means you have learned something about what kind of questions to ask, how to talk about this with someone. And it is clear that when you have attended that class, you enter such a conversation much more dauntlessly. (11)

A class about suicide had given this teacher tangible advice on how to talk about this with someone, which had made her more confident when engaging in such conversations. She was not asked how she would relate this to self-harm. However, as the class and experiences from it were mentioned in the context of self-harm, we interpret her to imply that a class about self-harm could have similar effects, and that confidence built through the increased knowledge about suicide was seen as generalizable to conversations about the topic of self-harm.

Another interviewee described how the experience of meeting a child who self-harmed had made him more aware:

If you had asked me a year ago, I would probably have answered that it hardly ever happens. But now I have experienced it myself, and I believe that it probably happens more often than you think. (10)

Having experienced a child who self-harmed first hand seems to have made this teacher realize that self-harm happens also among young children. He may have gained information on what to look for and to be more aware of the problem. In line with this, others related knowledge to visibility and awareness in more general terms:

You tell me that self-harm is increasing, but maybe that is also because we know more about it? There will always be two sides of the story. (6)

Even if not one single child self-harms in elementary school, I think that if I learned more about – well, I know quite a bit, but… If I learned more about self-harm and maybe the risk factors, it would have been advantageous for us in elementary school to know, so that we could maybe discover these children at an earlier stage. (9)

Participant 6 seems to convey that some of the apparent increase of self-harm might be accounted for by increased attention on the issue. Participant 9 relates knowledge of self-harm to the ability to discover children in distress at an earlier stage. As was suggested in the earlier theme regarding effects of widening people's definition of self-harm, interviewees felt that information about self-harm could make people more aware and that they thus would see more cases of self-harm. If these children are to be offered help it would require staff to interpret such actions as potential signs of distress. One school counselor commented on this:

I: So you think the reason why many of these children don't get help is that the teachers don't see the signals?
P: They see them, but they don't know that it is something you should report. They have not learned that. (12)

So in addition to knowing what kind of behaviors to look for, teachers must know that these signs, whether big or small, must always be taken seriously and be reported, which would allow someone to talk with the child face to face and get a broader understanding of how the child interprets the behavior.

In addition to the positive effects information may have on visibility and awareness, information about the functions self-harm might serve for children could contribute to promoting better understanding of the behavior:

But that teachers could be a little more generally informed, of that I am sure – to be able to communicate better understanding to those that self-harm. (9)

The participant states that more information could shift people's attitudes in a positive direction, contributing to children who self-harm being treated with the respect and care that they need. We argue that better understanding could have secondary effects by making this particular behavior feel more "logical" and less frightening. Timson and colleagues (2012) found poor knowledge to be significantly associated with negative attitudes towards adults who self-harm in a questionnaire-based study of 120 professionals, including 30 secondary

school teachers. An experimental study among 99 mental health and medical practitioners similarly demonstrated positive effects on attitudes of a class giving targeted training on the issue of self-harm (Treloar & Lewis, 2008).

Information about self-harm could also contribute to making school personnel more confident in encounters with children who self-harm. This was illustrated through two personal accounts in the beginning of this section, and is also pointed out in more general terms in the following quotation:

> *I think it would have been very important to offer a little information about self-harm to people working with children. If you discover, if you suspect – what is the main rule of how to handle it? (…)I think many are unsure and that is why I say that I think one should be informed a bit about it. (9)*

According to this participant there is a need for information and practical advice about what to do when a child is discovered to self-harm, because many people working with children are unsure about how to act. This is supported by the online survey where 71.4% of the respondents said they felt they had too little knowledge on how to act if they discovered a child who self-harmed. A survey done of 443 school counselors in the USA investigated how knowledgeable the participants deemed themselves to be on self-harm (root causes, symptoms and treatment of self-injury). They found that efficacy expectations increased with increased knowledge of self-harm. Similar findings were done in a study by Timson and colleagues (2012). Another study among 213 school welfare staff found positive effects on confidence, perception of own skills and knowledge of self-harm immediately after a short duration (one or two days) training program that focused specifically on how to work with adolescents who self-harm (Robinson, Gook, Yuen, McGorry & Yung, 2008). The effects persisted at a six-month follow up. These findings underscore the notion that more information could make school staff feel more secure, which again would increase the probability of them having the confidence needed to get involved when encountering children who self-harm.

Summed up, the majority of participants of both the interviews and the online survey desired more information about self-harm. There are several areas of knowledge that are important to cover. Personnel need to gain a basic understanding of self-harm that enables them to notice more children with such behavior. This necessitates a widening of the definition to include behaviors beyond cutting the skin. Knowledge of different functions of self-harm could help adults understand why some children harm themselves and shift staff attitudes in a positive

direction. Furthermore, school personnel need to be confident enough to actually reach out and talk to the child in question and be available if the child wants to talk to them about the subject. This could hopefully be accomplished by providing information related to how to talk with children about self-harm, or at least emphasizing that children who are discovered to harm themselves must be referred to someone who can take this responsibility. In light of these arguments, we want to emphasize that we consider it very important that school staff are provided with basic knowledge about all these aspects of self-harm. However, is this enough to make school staff sufficiently confident to interfere when discovering that a child self-harms? If the person who discovers this is a teacher, who has to manage classes and has 25 other pupils to attend to, who will give the child in question the necessary time and care? These challenges, together with other aspects related to staff's abilities to help children who self-harm, will be discussed throughout the next section.

3.3.2 Participants' feelings of inadequacy

This section presents interviewees' feelings of inadequacy in encounters with children who self-harm. The interview sample mainly consisted of school counselors. As a group they often talk with children with different kinds of problems. All school counselors we interviewed had met at least one child who self-harmed. Regardless of these experiences, many of them expressed feeling insecure about their level of competence in encounters with children who self-harm. Self-harm was often considered a behavior necessitating referral to professionals with education specifically focused on treatment of psychiatric illness, who they assumed to be in a better position to help these children:

But I, I, felt again that I could not do anything else. I could not deal with that alone, pretending to others that it had never happened. I needed professional help because I am a teacher by training, and the reason I am a school counselor is… Back in time when I was employed, I got the position because I had the best, the best… relationship with the kids. (2)

P1: No we must... Clearly, we have to pass it on.
P2: We are not therapists (…) so there we have to do our job, which means referring them for treatment. At the same time we have to be here and listen. (4)

We interpret these school counselors to perceive their role to include discovering incidents and supporting children through providing care and time to talk. Furthermore, they all express that self-harm in these cases was a worrying behavior calling for the need for professional

intervention, which, due to their position as school counselors, could not be offered by them. They thus felt that referral was implied. Participant 2 underlines that she was employed as a school counselor due to her good relationship skills with children. This is said with an undertone implying that these skills are not enough to actually make the children better. One of the interviewed teachers, similar to the school counselors, expressed a need for help from someone more competent:

More personnel would have been alright. In those particular situations it is… the opportunity to have someone proficient to help with that person. For instance when she comes to school and has experienced something difficult at home. It is not my thing at all. I am a pedagogue. (…) I saw the marks, right… But she would try to hide them at school; she did not want to show them. I thought it was a very difficult thing to bring up with her. (10)

Different from the school counselors who expressed that they felt they had something to contribute through being a caring conversational partner, this teacher made no differentiation between relational aspects and those relating to professional treatment. He expressed feeling uncertain about discussing the topic of self-harm with this child, and he expressed that dealing with this was outside the scope of his role as a pedagogue. Similar expressions of uncertainty were evident in the aftermath of the previously described dance performance. This spurred inquiries to a Norwegian support organization for women with eating disorders called "Interessegruppa for Kvinner med Spiseforstyrrelser" from teachers having seen the show, wondering what to do; how to talk about this with the students in general and how to relate to pupils with strong reactions to it. They felt they lacked competence and were afraid of doing or saying something wrong (M. I. S. Pettersen, personal communication, December 20, 2012).

Another participant, employed as an assistant teacher, described general confidence about working with children facing difficulties. This included talking with children with externalizing problems, as well as dealing with problems at group level. Regardless of this, he expressed uncertainty when reflecting on possible encounters with children who self-harm:

In many cases you can see that either something works, or it doesn't. You have kind of tested it out. (…) But when it comes to self-harm, I guess that is something you so seldom encounter that you don't have the opportunity to do that. Fights happen almost daily at some schools, thus you can test out what works and what doesn't. But as you say, with self-harm there has been so little research, so you are afraid of doing something you should not. (1)

This assistant teacher was uncertain about encountering children who self-harm for two reasons; lack of scientifically based knowledge and lack of personal experience. In the online

survey, 36% of the staff members who had observed a child who self-harmed at their school said they felt they had enough knowledge to know how to act if they were to discover a child who self-harms in the future. 63% said they felt they needed more knowledge. In comparison, of those with no experience, only 20% felt they had enough knowledge to know how to act, while 80% said they felt they needed more knowledge. A two-tailed p-value of a Chi-square equaled 0.1510 (see Table 5) which is not significant, but may illustrate a trend in the data.

Table 5: The relationship between experience and need for more knowledge

	Do you feel that you have enough knowledge on how you should act if you discover a child in your class who self-harms?		
Have you ever observed a child (6-13 years old) engage in behaviors you interpreted as self-harm?		Yes	No	Total
	Yes	12	21	33
	No	6	24	30
	Total	18	45	63

Perhaps staff members that have experienced children who self-harm and who successfully managed the situation, gained self-efficacy and therefore feel less insecure about how to handle a future incident. It may also be that staff who lack experience might draw a distinction between self-harm and more familiar behaviors, and may consequently see self-harming behavior as a problem to be handled by specialists only. Opposed to this, staff with experience may not see self-harm as qualitatively different from other situations they are expected to handle on a daily basis. In line with this reasoning, it could be argued that the type of behavior a child exerts is not totally decisive for how to interact with the child, but that there are some common approaches that can be helpful for struggling children, regardless of the nature of the child's problem. This will be given a closer look throughout the next section.

3.3.3 How schools and school personnel can help children who self-harm

School staff are likely to encounter children who self-harm through their work. It is important both for their own and for the children's sake that they feel confident enough to talk with

them about these things. Elementary school staff should at the same time not be required to act as therapists, and there might be cases where referral to external help systems is the preferred option. We want, however, to underline once again the mechanisms of change that may be triggered by merely talking to a genuinely caring and secure adult about topics of personal importance (Lambert & Barley, 2001; Patterson, 1984). In light of this, school personnel may be contributing more to positive change than they acknowledge themselves. We consider that knowledge about the therapeutic effects of common factors should be made available to school staff, which could make them feel more confident about the possible change-promoting effects of their contributions. In cases where school employees feel referral is the right option, they are sometimes hindered by long waiting lists for psychiatric treatment. Such standstills might be easier to handle with knowledge of common factors in hand.

There are greater limitations to what should be expected of those employed as teachers and assistants as opposed to school counselors when it comes to helping children who self-harm. One teacher reflected on some weaknesses of the teachers' education that could also be related to feelings of inadequacy in encounters with children who self-harm.

We had far too much focus on theory. Too little focus on social interaction in class, contact with parents and class leadership. These things should gain much more attention; you should have much more practice. (10)

The interviewee feels that there are many aspects of the teacher's role that their training does not prepare one for. He thinks the education should be directed more towards facing things that knowledge of the curriculum cannot prepare you for. This is important feedback to the educational system, but it also serves to underscore that many teachers are left with too much responsibility. One interviewee pointed on the fact that systemic organization inside schools is of great importance:

I think that if a school has at least one or two persons who know a lot or a little more, it is important to have a system that if you suspect a child or another to self-harm, you go on and contact them, because there is no way we can master everything. (9)

What she seems to want to convey is that school personnel are employed to cover different areas of responsibilities. Teachers are facing time and resource constraints that cannot be ignored, and they are, first of all, trained and employed to teach children the curriculum. Because of their position, teachers nevertheless have the advantage of seeing a great number of children for several hours each day. It is of great importance for getting early professional

help that an adult discovers the self-harming behavior of a child, as children are far less likely to seek such help on their own (Mojtabai & Olfson, 2008). Teachers can thus come to play very important roles as gate keepers, being the first ones to discover the children and then ensuring referral to right services (Hawton et al., 2012). This necessitates a school counselor position, which is not bound in such degree to other responsibilities. In some cases, it might not be right on behalf of the child to leave all the responsibility with the counselor. The teacher's involvement might be important because he or she is the person the child knows best and has trust in. In such cases responsibilities could be shared. Besides lifting some of the responsibility off teachers, teachers might also feel far better prepared to deal with these children when having a trusted colleague to turn to for emotional support and advice.

We asked the participants of the online survey what they thought should be done in the case of discovering a child who self-harms. Their answers serve to underline what has already been discussed throughout this section. The results from the survey can be found in Table 6.

Table 6: What staff think should be done when self-harm is discovered

WHAT SHOULD BE DONE WHEN SELF-HARM IS DISCOVERED	NUMBER OF REPLIES
Seeking help internally – from other school staff; school nurse, school counselor, principal, school health/resource team	45
Contact parents or guardian*	41
Seeking help externally – from child psychiatric unit, child services, school psychologists	27
Talk/interact with the child	23
Try to find interventions (trying to establish a good relation with the child, finding alternative ways of behaving together with the child, caring)	10

* Some said "when appropriate", stressing that this may not always be appropriate if the parents do not seem able to care. In such cases they would contact child services instead.

The findings illustrate that the majority of staff members would prefer guidance and supervision from colleagues and/or collaborating with the child's parents or guardians. Many would also desire help from outside agencies. A minority said they would interact with the child, and even fewer would try to help find alternative ways of behaving and care for the

child. That the majority regarded internal resources so important once again serves to underline how essential it is for schools to have someone specifically employed to take care of such issues. Also, in light of what has already been discussed about how important it is that children are seen and cared for, it might serve as a wake up-call that only 37% said they would talk directly with the child, and only 16% said they would try to establish a good relation, care for her/him and/or find alternative ways of behaving.

To sum up, we consider the main implication from the findings presented throughout this theme to be a call for more knowledge. We suggest that school staff can be empowered by being provided with basic information about self-harm and about common factors of therapy. Increased knowledge will serve both children and the staff, as greater knowledge has been found to affect both staff attitudes and feelings of personal efficacy (Timson et al., 2012). Gaining confidence and being willing to talk to the individual child to better understand the behavior and making the child feel respectfully treated can go a long way instead of waiting for outside agencies to take over. School staff may have an important role in a first step in an intervention process, even in cases that would eventually require outside treatment.

4 Conclusion and implications

The findings of this study have implications for the elementary school's roles regarding prevention, care and help to children who self-harm. Recent research confirms that young children engage in self-harm behaviors, but that there are developmental trends which staff working with young children should be aware of to increase the chances of detection. We stress the importance of staff talking to children directly to better understand what underlies the behavior and what the self-harm means for the individual child. This will help the child feel that he or she is seen and being taken seriously by caring and secure adults.

The potential social learning effects of talking about self-harm was preoccupying most of the interviewees, although perceived positive aspects of talking about self-harm seemed to outweigh potential negative effects. Arguments in favor of talking about self-harm included reducing the taboo surrounding self-harm, increasing the probability of peers discovering and reporting to adults if a child self-harms, promoting greater knowledge and awareness, promoting understanding and a supporting attitude towards those children who self-harm, allowing children who self-harm to experience that they are not alone and the possibility of putting self-harm in perspective by suggesting alternative coping methods. In the context of social learning effects, one must be careful not to underestimate what children pick up through other channels like media, family or friends. The school could be a safe arena where information on self-harm could be shared within a deliberate framework. We argue that self-harm should not be discarded as a topic of discussion with children, but that there is a need to adjust information so that the dangers of social learning effects are minimized and positive mental health effects maximized. It is essential that information on self-harm is presented in an environment made up of caring adults and with a clear message about who children can contact if needed. School counselors should be highly visible and familiar for all children at school, and the threshold for contacting them and other school staff regarding any kind of issue should be low. This provides an alternative to the external helping system which, in general, is less available.

Many of the participants of the current study expressed feeling insecure about what they could contribute to children who self-harm, and often saw the behavior as necessitating referral to outside agencies. We want to encourage that elementary school staff should be made aware of the positive, change-promoting effects of common factors of therapy. Many of these are

qualities that school staff can and do, in fact, already contribute, including positive regard, communication of caring and respect and emphatic understanding.

Most of the interviewees were school counselors. Ordinary teachers' roles differ from school counselors' regarding resources to care for the individual child. Teachers are nevertheless the ones with the most frequent contact with the children, and they are in an ideal position to act as gatekeepers through discovering self-harm in children and helping them by referring to adults with the available time and security needed (Hawton et al., 2012). If the children's needs are to be met, teachers will have to be secure enough to deal with a potential child who self-harms. The teachers' reported insecurities about dealing with such issues must be taken seriously. More knowledge of self-harm and how to properly deal with it should be given to elementary school staff. At the same time, time restraints, lack of resources and a feeling of lacking competence should not be ignored. This stresses the need to clarify the boundaries of what can and cannot be expected in terms of the class teacher's role, as well as what could be done both during education and in work to make teachers feel as able as possible to deal with children's psychological problems, including self-harm.

We suggest a well-working system with the components described here is of such importance that it calls for fundamental changes regarding two aspects pertaining to the Norwegian elementary school system. Firstly, to better the chances of discovering self-harm, to meet these children with respect and to have greater confidence on what to do in encounters with them, it should be compulsory that all school staff have a minimal of knowledge regarding self-harm and common factors of therapy. Secondly, the position of a school counselor or an equivalent should be a requirement for all elementary schools. School counselors should be offered relevant supervision to make them feel more secure in how to handle situations where children engage in self-harm. The position of a school counselor encompasses many aspects that class teachers do not have the capacity to fill. A school counselor can convey their updated knowledge on self-harm (and other relevant topics) to other staff, for example once every six months. This serves to keep the topic of self-harm in mind and to maintain an awareness of the problem which can promote children being discovered sooner. This could also contribute to reduce the feeling among teachers of not being able to offer individual children what they need in terms of time and care. Furthermore, having a counselor at school lowers the bar for teachers to get involved with such problems, knowing that there is someone available with competence and experience. The school counselor can provide support for

teachers in these instances, and we believe that caring and empathic teachers can promote positive change for children who may face long queues to gain access to external health systems. Close cooperation between school counselors and the rest of the school staff as well as with children's families and community mental healthcare centers is of course also of importance.

For future research, it would be valuable to hear the children out on what sort of help they would prefer, and how they experience the school as an arena for help and support. Future studies could focus on the topic of social learning of self-harm, and on how best to talk about self-harm with children without provoking unbeneficial outcomes.

4.1 Considerations/limitations

The majority of the interview subjects were school counselors, and this paper reflects their views and experiences more than the classroom teacher, although several participants possessed a dual role of both teacher and school counselor at their school. School counselors are expected to talk to children and care for them on a more individual level than are the teachers. The survey data is likely colored by staff who had experience with self-harm or had a personal interest in the subject. However, the goal of this paper was not to give a Norway-wide survey of school staff in general, and we hope to have succeeded in providing a focused study of staff with a particular interest in the topic of self-harm and with a genuine interest in children's emotional wellbeing.

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Appendix A: Online survey

Selvskading blant barneskolebarn. En spørreundersøkelse til barneskoler.

Svarene i dette skjemaet er anonymisert.

Ved å svare på denne spørreundersøkelsen samtykker du til at besvarelsen din kan brukes i forskning. Svarene dine overleveres oss helt anonymt. Vi ber om at du ikke oppgir navn eller identifiserende bakgrunnsopplysninger, verken om deg selv eller elever/barn, i spørreskjemaet.

Jeg samtykker til å delta i studien: *

- Ja
- Nei

1.0 Demografisk informasjon

1.1 Kjønn *

1.2 Hva er din alder? *

- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60+

1.3 Stilling *

Hva er din stilling i barneskolen?

1.3b Hvilke klassetrinn arbeider du med til daglig? *

- ☐ 1. - 3. trinn
- ☐ 4. - 7. trinn
- ☐ 8. - 10. trinn

1.4 I hvor mange år har du arbeidet med barn? *

1.5 Har du barn selv? *

- ● Ja
- ● Nei

1.6 Hvis JA på 1.5: Hva er barnets/barnas alder?

2.0 Din forståelse av selvskading

2.1 Hvilke type handlinger forbinder du med ordet “selvskading”? Tenk etter, og skriv ned handlinger som du vil tolke som selvskading. *

Vi har i likhet med flere andre studier valgt å ta utgangspunkt denne definisjonen* hvor selvskading beskrives som: «En ikke-dødelig handling hvor individet med overlegg gjør en eller flere av følgende handlinger: • Skader seg selv med vilje (som f.eks. kutter seg, hopper fra en høyde, pirker seg til blods, brenner huden, stikker seg med blyanter, stifter seg i huden etc.) • Inntar et legemiddel utover foreskrevet eller anbefalt medisinsk dose • Inntar et ulovlig stoff og selv anser dette som selvskading • Inntar ikke-spiselige stoffer eller objekter». *Child & Adolescent Self-harm in Europe (CASE) studien.(Madge, 2008)

3.0 Erfaringer med selvskading blant barn

3.1 Har du noen gang observert et barn (6-13 år) utføre handlinger som du tolket som selvskading? *

- ● Ja
- ● Nei

3.2 Hvis JA på 3.1: Hvilke type atferd observerte du?

3.3 Har du noen formening om hvorfor dette barnet selvskadet?

Velg de alternativene du mener passer.

- ☐ Fordi barnet følte seg sint eller frustrert
- ☐ Fordi barnet følte seg ulykkelig eller lite elsket
- ☐ En form for eksperimentering
- ☐ For ta kontroll
- ☐ For å irritere
- ☐ Et rop om hjelp
- ☐ For å slippe å delta i aktiviteter på skolen
- ☐ Pga. en negativ hendelse på skolen, f.eks krangling med en venn
- ☐ Familieproblemer; finansielle, sosiale, emosjonelle
- ☐ Pga. dårlig oppdragelse
- ☐ For å oppnå en lykkefølelse
- ☐ For å straffe seg selv
- ☐ Pga. at barnet blir mobbet
- ☐ Nei, ingen formening

3.4 Hvis NEI på 3.1: Selv om du ikke selv har observert et barn som selvskader, har du gjennom andre hørt om et barn (6-13 år) som har utført handlinger du tolker som selvskading?

- ● Ja
- ● Nei

3.5 Hvis JA på 3.4: Hva har dette barnet gjort som du tolker som selvskading?

4.0 Årsaker til selvskading

4.1 Hva tror du kan være årsakene til at enkelte barn tyr til selvskading? *

5.0 Et tema i skolen?

5.1 Er selvskading et tema som noen gang har vært diskutert i personalgruppa på din skole? *

- Ja
- Nei

5.2 Tenker du at det er behov for mer informasjon om selvskading med tanke på forebygging og evne til håndtering av problemet? *

- Ja
- Nei

Hvis JA på 5.2: Mener du informasjonen bør rette seg mot voksne (foreldre/lærere), mot barna, eller begge?

- Voksne
- Barn
- Begge

5.3 Tenker du at forekomsten av selvskading blant barn kan komme til å øke dersom barn får mer informasjon om selvskading? *

- Ja
- Nei
- Usikker

5.4 Hva mener du en burde gjøre som ansatt dersom en oppdager et barn som selvskader? *

5.5 Føler du at du har nok kunnskap om hvordan du burde handle hvis du oppdager et barn i din klasse som selvskader? *

- Ja
- Nei

5.6 Hvilken type støtte eller hjelp mener du vil være viktig for deg hvis du oppdager et barn som selvskader? *

6.0 Kommentarer

6.1 Har du noen kommentarer til undersøkelsen, spørsmålene eller temaet helt til slutt?

7.0 Intervju

I tillegg til dette spørreskjemaet ønsker vi å gjennomføre intervjuer med et lite utvalg av lærere på Østlandet om temaet barneskolebarn og selvskading. Dersom du har lyst til å stille til intervju, ber vi om at du kontakter oss på epostadressene våre; tanjamar@student.matnat.uio.no eller annsv@student.sv.uio.no. Intervjuet vil vare ca. en time og vi blir sammen enige om tid og sted.

Appendix B: Information letter sent by email to schools with link to the online survey

Hei!

Vi er to studenter ved profesjonsstudiet i psykologi ved Universitetet i Oslo, og tar kontakt med dere i forbindelse med vårt hovedoppgaveprosjekt. I hovedoppgaven har vi valgt å fokusere på temaet selvskading blant barneskolebarn, og skal i denne sammenheng gjennomføre en spørreundersøkelse. Prosjektet er meldt til Personvernombudet for forskning ved Norsk Samfunnsvitenskapelig Datatjeneste (NSD). Vi vil være svært takknemlige om dere vil videreformidle skrivet under til deres ansatte for 1. – 7. klassetrinn. I skrivet finnes utfyllende informasjon om studien samt en link til spørreundersøkelsen.

Alle besvarelser er av stor verdi.

På forhånd takk for hjelpen!

Mvh.
Tanja Marie Hirsch og Ann Kristin Svendsen
Psykologstudenter, 11. semester, UiO.

Under følger informasjonsbrev om undersøkelsen til de ansatte (med link til spørreskjemaet):

Hei!

Vi er to studenter ved profesjonsstudiet i psykologi ved Universitetet i Oslo, og tar kontakt med deg i forbindelse med vår hovedoppgave. Skolen du er tilknyttet har formidlet denne henvendelsen for oss.

I hovedoppgaven vår har vi valgt å fokusere på temaet selvskading blant barneskolebarn. Det er begrenset med tid til undervisning om ulike emner på studiet. Selvskading er et av temaene vi ønsker å lære mer om, og vi så hovedoppgaven som en fin mulighet til dette. I denne sammenhengen ønsker vi å få innblikk i tanker og eventuelle erfaringer til lærere til barn i alderen 6-13 år. Det er et tema det finnes lite forskning på fra før av, og vi anser det som viktig å få større kunnskap om dette. Data til prosjektet innhentes ved spørreskjema fra ca. 100 deltagere fra ulike skoler i Norge, og intervju med et mindre utvalg.

Lenger ned i mailen vil du finne en link til et spørreskjema angående dette temaet. Det er ingen rette eller gale svar på spørsmålene - vi er interessert i din forståelse av selvskading. Ditt bidrag er viktig for oss enten du har gjort deg noen tanker om temaet tidligere eller ikke!

Svarene dine overleveres oss helt anonymt. Vi ber om at du ikke oppgir navn eller identifiserende bakgrunnsopplysninger, verken om deg selv eller elever/barn, i spørreskjemaet.

vi

Dersom du har lyst til å stille til intervju, ber vi om at du kontakter oss på epostadressene våre nedenfor. Intervjuet vil vare ca. en time og vi blir sammen enige om tid og sted. Vi ønsker å gjøre lydopptak av intervjuet. Opptakene slettes og intervjumaterialet anonymiseres ved prosjektslutt 30. mai 2013.

Prosjektet er meldt til Personvernombudet for forskning ved Norsk Samfunnsvitenskapelig Datatjeneste (NSD). Deltakelse er selvfølgelig helt frivillig, men hvert eneste svar er verdifullt for å kunne gjennomføre prosjektet. Du kan når som helst trekke deg fra undersøkelsen, dersom du ønsker det. Det er kun vi som skriver hovedoppgaven og vår veileder som vil ha tilgang til dataene.

Alle svar er viktige for oss, og vi håper derfor at du har lyst og mulighet til å bidra i denne studien angående selvskading blant barneskolebarn. Tusen takk for at du tar deg tid!

Link til spørreundersøkelsen: https://nettskjema.uio.no/answer/selvskadinglarer.html

Hvis du har spørsmål eller kommentarer til undersøkelsen kan du kontakte oss på telefon eller mail:
Tanja Marie Hirsch, tanjamar@student.matnat.uio.no: telefon: 980 88 930
Ann Kristin Svendsen, annsv@student.sv.uio.no: Telefon: 938 58 398

Du kan også kontakte vår veileder, forsker Katrina Roen ved Universitet i Oslo, på mailadressen katrina.roen@psykologi.uio.no.

Med vennlig hilsen

Ann Kristin Svendsen og Tanja Marie Hirsch

Appendix C: Interview guide

1. **Jeg starter med et veldig åpent spørsmål. Jeg lurer på hva du tenker når du hører temaet barneskolebarn og selvskading?**

2. **Har du noen gang kommet i kontakt med barn som har selvskadet i barneskolen? Kan du fortelle oss om et slikt tilfelle?**

- Hva var det dette barnet gjorde som du tolket som selvskading?
- Har du noen tanker omkring hvorfor dette barnet skadet seg selv?
- Hva ble gjort i forhold til barnet? (Kontakt med ledelse/andre kollegaer/foreldre først?
- Ble barnet henvist videre til helsepersonell/hvor fort? Hva skjedde med barnet i mellomtiden?
- Involverte skolen/lærere seg ut over å henvise videre? Hvis ja; Kan du fortelle nærmere om hvordan dette samarbeidet foregikk?
- Snakket du med barnet om selvskadingen? Dine følelser i forhold til dette?
- Ble det gjort noe i forhold til resten av klassen til barnet?
- Hva gjorde det med deg å oppleve å komme så nært inn på et barn som selvskadet/ hadde det vondt?
- Kan du fortelle oss litt om hvordan du som person taklet følelsene som dukket opp i møte med dette barnet? Kan du fortelle litt om hva du føler hjalp deg med å takle dette? Var det noe du savnet av støtte?
- Kan du fortelle om din opplevelse av å forsøke å hjelpe barnet? (følelse av maktesløshet? Av å gjøre en forskjell?)
- Hvordan tenker du rundt dette i dag? Ville du gjort noe annerledes når du ser tilbake på det?

3. **Selvskading er et omdiskutert begrep, og det finnes mange tanker rundt hva selvskading er og ikke er. Vi vil gjerne høre noen eksempler på handlinger du ville ha sett på som selvskading?**

4. **Hvordan rolle opplever du som lærer at skolen har i forhold til barns psykiske helse?** *Ansvar/kompetanse/tid/ressurser?*

   Hvordan setter skolen du jobber ved fokus på psykisk helse? *Satt av tid til å prate med kolleger om problemer? Generelt/om enkeltelever?*

   Vi er interessert i å høre om hva slags samarbeid skolen har med foreldrene til den enkelte elev. Kan du fortelle oss litt om dette? Har du vært med på foreldresamtaler ved skolen du jobber? Hvordan opplever du disse samtalene? *Hva er tema i disse samtalene? Settes det fokus på psykisk helse/hvordan/hvor mye (bare hvis det er kjent at eleven det gjelder sliter, eller tar man det opp uansett)?*

Kan du fortelle litt om samarbeidet mellom skolen og andre instanser (helsesøster, ppt, bup, foreldre) når barn har det vanskelig? Når det gjelder forebyggende arbeid i forhold til psykisk helse?

Selvskading er et utbredt problem blant ungdom. Vi lurer på om du har du noen tanker rundt behovet for forebygging av selvskading allerede i barneskolen?

Hvorfor/hvorfor ikke fokusere på forebygging av selvskading.

Tanker rundt fordeler eller ulemper ved å ta opp selvskading som et tema for diskusjon blant barn?

Anses selvskading som et økende problem? Årsaker til dette? Aktuelt kun for lærere med erfaringer fra selvskading?

5. **Har du noen tanker rundt hvordan du som lærer kan være til hjelp for barn som selvskader?** Kan også spørre om; **Elever som har det vanskelig (generelt)?**

   Kan du fortelle litt hvordan det oppleves å komme ut for slik problematikk i en hektisk hverdag? Hvordan blir du møtt av kolleger, av ledelsen. Oppleves det at det finnes tid til problematikk som kommer utenfor den typiske lærerrollen?

6. **Kan du fortelle oss om dine tanker rundt hvorfor noen barn velger å skade seg selv?** (huske å forsøke å få frem om den vi intervjuer har tanker både rundt *selvskadingens funksjon der og da; hva er det selvskadingen "gir" barnet*? I tillegg til mer *bakenforliggende årsaker*)

7. **Er det noe mer du vil spørre om eller legge til før vi avslutter intervjuet?**

Åpnende spørsmål:

Kan du fortelle meg om…

Husker du en hendelse hvor…

Hva skjedde i den episoden du nevnte?

Jeg er interessert i å høre om din opplevelse av

Jeg ønsker å gå litt tilbake til det du fortalte tidligere, og høre (mer) om…

Oppfølgingsspørsmål:

Kan du si noe mer om dette?

Kan du gi en mer detaljert beskrivelse av hva som skjedde?

Har du flere eksempler på dette?

Spesifiserende spørsmål:

Hva gjorde du når du følte deg hjelpesløs (for eksempel)

Indirekte spørsmål:

Opplever du at andre mener at

Klarifiserende spørsmål:

Mener du da at

Er det riktig at du føler at

Appendix D: Letter of informed consent signed by interview subjects

Samtykke til deltagelse i forskningsprosjekt angående barn og selvskading.

Jeg har lest informasjonsskrivet, og samtykker til at informasjon jeg gir i intervjuet kan brukes i dette forskningsprosjektet. Jeg vet at jeg når som helst under intervjuets gang kan velge å trekke meg, uten nærmere forklaring angående hvorfor jeg velger å gjøre dette.

Sted & dato: _____

Underskrift: _____

Appendix E: Information letter to principals and interview subjects

Hei!

Vi er to studenter ved profesjonsstudiet i psykologi ved Universitetet i Oslo, og tar kontakt med deg i forbindelse med vårt hovedoppgaveprosjekt. Temaet for oppgaven er selvskading blant barneskolebarn. Målet med studien er å få økt kunnskap omkring dette, for eksempel om hvordan man som lærer kan fange opp og møte disse barna og deres nærmeste. Det er gjort en tilsvarende studie blant lærere til barneskolebarn i Storbritannia tidligere. Selvskading blant denne aldersgruppen er ellers et tema det finnes lite forskning på fra før av, og vi anser det som viktig å sette fokus på problematikken. Vi er interessert i å få innblikk i tanker og eventuelle erfaringer til lærere til barn i alderen 6-13 år, og ønsker å intervjue både personer som har gjort seg noen tanker om temaet tidligere eller ikke.

Prosjektet er meldt til Personvernombudet for forskning ved Norsk Samfunnsvitenskapelig Datatjeneste (NSD). Dersom du under intervjuets gang skulle ønske å trekke deg, har du full anledning til å gjøre dette, uten å oppgi noen videre begrunnelse. Det er kun vi som skriver hovedoppgaven og vår veileder som vil ha tilgang til dataene. Intervjumaterialet vil selvsagt anonymiseres i den endelige oppgaven, og det vil ikke komme frem informasjon om skoletilknytning eller liknende. Vi ber ellers om at du ikke oppgir navn eller identifiserende bakgrunnsopplysninger, verken om deg selv eller elever/barn, i intervjuet.

Alle bidrag er viktige for å øke kunnskapen om temaet, og vi håper derfor at du har lyst og mulighet til å dele dine tanker i denne studien angående selvskading blant barneskolebarn.

Tusen takk for at du tar deg tid!

Hvis du ønsker å stille til intervju eller har spørsmål/kommentarer til dette kan du kontakte oss på telefon eller mail.

Tanja Marie Hirsch, tanjamar@student.matnat.uio.no: telefon: 980 88 930

Ann Kristin Svendsen, annsv@student.sv.uio.no: Telefon: 938 58 398

Du kan også kontakte vår veileder, forsker Katrina Røn ved Universitet i Oslo, på mailadressen katrina.roen@psykologi.uio.no.

Med vennlig hilsen

Ann Kristin Svendsen og Tanja Marie Hirsch

Appendix F: Letter from NSD

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Katrina Roen
Psykologisk institutt
Universitetet i Oslo
Postboks 1094 Blindern
0317 OSLO

Vår dato: 14.05.2012 Vår ref:30452 / 3 / IB Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 16.04.2012. All nødvendig informasjon om prosjektet forelå i sin helhet 08.05.2012. Meldingen gjelder prosjektet:

30452	*Barneskolebarn og selvskading*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Katrina Roen*
Student	*Ann Kristin Svendsen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 30.05.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Inga Brautaset

Kontaktperson: Inga Brautaset tlf: 55 58 26 35
Vedlegg: Prosjektvurdering
Kopi: Ann Kristin Svendsen, Kanalveien 9, 2004 LILLESTRØM

Avdelingskontorer / *District Offices*:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no